Supreme Court, U.S.
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No. 96-

In The
Supreme Court of the United States
October Term, 1996

State of Louisiana, ex rel. RICHARD P. IEYOUB,
Attorney General
Petitioner

v.

CIGNA Health Plan of Louisiana, Inc. and
Connecticut General Life Insurance Co.
Respondents

On Petition for Writ of Certiorari to the United States Fifth Circuit Court of Appeals

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PETITION FOR WRIT OF CERTIORARI

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84 pp

QUESTIONS PRESENTED FOR REVIEW

1. Was it the *intent* of Congress in enacting the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. 1001 et seq., to prohibit states from including an "any willing provider" provision in a preferred provider organization enabling statute, when the state health care statute does not relate to ERISA plans, does not impinge upon the objectives of ERISA by mandating employee benefit structures or benefits in the sense required for pre-emption, does not provide alternate enforcement mechanisms, does not operate to "effectively restrict' the choice of policies available in the market, is not predicated upon the existence of ERISA plans, does not single out ERISA plans for special treatment, and *may* affect them only in an indirect economic manner, but rather, does regulate a contractual agreement to provide health care services *(insurance)* between health care providers and group purchasers of health care services, which may be utilized by ERISA plans, by providing that no licensed provider who agrees to the terms of the contract shall be denied the right to become a preferred provider.

2. May a citizen of another state doing business within the state use the judicially created exception to the states' Eleventh Amendment immunity of *Ex parte Young* to sue a state in its own name through its attorney general in federal court to enjoin a civil statute, not unconstitutional on its face, to declare a section of the statute unconstitutional and enjoining the state officer from enforcing it, thereby nullifying the state's significant constitutional guaranty by alleging ERISA preemption of a civil health care statute, using the Fifth Circuit's own judicially created legal rule that *regardless* of the strong legal presumption against preemption, a federal court *always* has jurisdiction to determine if state officers are violating federal law, when this Court has held previously that health care regulation statutes do not relate to ERISA plans and thus, do not need to be "saved" from preemption, when the *Ex parte Young* Court itself, held such action to be *inconsistent with the Constitution*, when this Court has previously ruled that suits against an officer of the state in his official capacity are suits against the state itself, *and* when this Court has

recently held that even when the Constitution vests in Congress complete law-making authority over a particular area, the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States.

PARTIES TO THE PROCEEDINGS

All parties to this proceeding appear in the caption of the decision of the United States Court of Appeals for the Fifth Circuit, which is contained in the appendix at pages 3a-15a.

In accordance with Supreme Court Rule 29.1, Petitioner State of Louisiana, through its Attorney General, states that it does not have a corporate parent or subsidiaries.

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In The
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State of Louisiana, ex rel. RICHARD P. IEYOUB,
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Appealed from the United States Fifth Circuit Court of Appeals

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PETITION FOR WRIT OF CERTIORARI

Petitioner State of Louisiana, through its Attorney General, respectfully petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals for the Fifth Circuit is reported at 82 F.3d 642. It is reproduced in the appendix at 3a to 15a. The decision of the United States District Court for the Eastern District of Louisiana is reported at 883 F. Supp. 94. It is also reproduced in the appendix at 17a to 35a.

JURISDICTION

The judgment of the Court of Appeals was initially entered on April 30, 1996. On May 13, 1996, a petition for rehearing was filed. On June 4, 1996, the petition for rehearing was denied. That order is reproduced in the appendix at 1a. Pursuant to Rule

13 of the Rules of the Supreme Court of the United States, this petition is timely filed within ninety (90) days of the date of the denial of rehearing, which time ends on September 3, 1996. This Court has jurisdiction pursuant to 28 U.S. C. 1254(1).

STATUTORY PROVISIONS INVOLVED

1. The relevant statutory provisions are:

(a) ERISA 514(a), (codified at 29 U.S.C. 1144(a) (1988)), which provides that:

> Except as provided in subsection (b) of this section, the provisions of this Subchapter and Subchapter III of this Chapter shall supersede any and all State laws insofar as they may now or hereafter related to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect of January 1, 1975.

(b) ERISA 514(b)(2)(A), (codified at 29 U.S.C. 1144(b)(2)(A) (1988)), the insurance saving clause, which provides that:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(c) Title 40 Public Health and Safety, Chapter 12, Health Care Cost Control, (40:2201, et seq.), of the Louisiana Revised Statutes of 1950, a copy of which is set forth in the appendix at 37a to 42a.

STATEMENT OF THE CASE

This action involves a challenge by an HMO and an insurance company, under the Supremacy Clause of the United States Constitution, to the statutory method by which Louisiana, through its health care laws, controls health care costs without jeopardizing the quality of care received by patients. Claiming

jurisdiction under 28 U.S.C. 1331, and the *Ex parte Young* exception to the State's Eleventh Amendment immunity from suit in federal court, plaintiffs-respondents Cigna Health Plan of Louisiana, Inc. ("CIGNA") and Connecticut General Life Insurance Company ("CGLIC") filed a complaint seeking declaratory and injunctive relief on the theory that the Any Willing Provider provision of Louisiana's Preferred Provider Organization enabling statute violated the Supremacy Clause of the United States Constitution, on July 19, 1994, in the Middle District of Louisiana, in Baton Rouge, Louisiana, naming as defendant the State of Louisiana through its Attorney General, Richard P. Ieyoub.[1] Although claiming *Ex parte Young* type of injury, notably, they did not pray for a temporary restraining order.

On August 9, 1994, the State of Louisiana filed a Motion to Dismiss the case, based upon the Eleventh Amendment, the Declaratory Judgment Act, the Federal Injunction Act, Failure to State a Cause of Action, Lack of Standing, and Lack of an Actual Case of Controversy to both counts of the Petition, which was set for hearing by the Court on March 17, 1995, as the earliest available date. Plaintiffs then filed a Motion for Summary Judgment on October 13, 1994, noticing it for hearing on the same day as the State's Motion to Dismiss. The State filed its Opposition on October 20, 1994. Before the hearing, the Middle District Court transferred the case to the Eastern District of Louisiana, in New Orleans. The Eastern District denied Plaintiffs' Fourteenth Amendment complaint, but, ironically, dismissed the State's Eleventh Amendment claims and found ERISA preemption, enjoining Louisiana's Attorney General from enforcing the state statute.

The Court of Appeals below held that the suit was not barred by the Eleventh Amendment because it is "well estab-

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[1]CIGNA and CGLIC also sought declaratory and injunctive relief on the theory that the Any Willing Provider statute violated the Fourteenth Amendment of the United States Constitution. The district court dismissed the claim for failure to state a claim. CIGNA and CGLIC did not challenge this ruling on appeal.

lished that the federal courts have jurisdiction to hear suits against state officials where, as here, the plaintiffs seek only prospective declaratory or injunctive relief to prevent a continuing violation of federal law" and that federal law was violated because ERISA preempts the Louisiana statute in that it "relates to "employee benefit plans within the meaning of ERISA's preemption clause. It held further, that the statute is not exempted from preemption by ERISA's" insurance savings clause" because the statute failed to meet the third factor of the ***Metropolitan Life*** test[2]. The Court thought it sufficient for preemption under ERISA that "on its face, Louisiana's statute obviously is not 'limited to entities within the insurance industry,'" because it "specifies, in a non-exclusive list, that it 'applies' to "self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs," as well as 'health care financiers, third party administrators, providers, or other intermediaries.'" La. Rev. Stat. Ann. 40:2202(3)(a) and (b).

However, the statute does not state that "it applies" to self-insured plans. It specifically states that a preferred provider organization shall mean a contractual agreement between a provider and a group purchaser to provide health care services. It confers the right upon self-insured plans to employ such a contract, should *they* so choose. Thus, it does not relate to ERISA plans, because it regulates a contract of insurance and affects plans only in an indirect economic manner.

Similarly, the Appellate Court dismissed Louisiana's and its Attorney General's claims of sovereign immunity as "patently without merit." A3, FN1. The Fifth Circuit relied heavily upon its own decision, to disregard Louisiana's and its Attorney General's Eleventh Amendment immunity in deciding this matter. A3, FN1. That decision pre-dates one of this Court's latest authorities on the subject which holds that a state may not be sued in its own name, regardless of the relief sought and pre-dates this Court's latest expression of the law holding that Congress may not abrogate that immunity even when the Constitution vests in Congress

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[2]*Metropolitan Life Insurance Co. v. Travelers Insurance Co.*, 471 U.S. 725, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

complete law-making authority over a particular area, ie., in pre-emption issues.

The Fifth Circuit reasoned, by relying on its previous case, that whenever a plaintiff *alleges* that state officials are violating federal laws, a federal court *always* has jurisdiction to determine whether or not a violation has occurred. Such a legal hypothesis runs contra to the *Ex parte Young* Court's opinion itself, which warned that such action is not consistent with the Constitution.

The decision further conferred employer standing under ERISA on HMOs and insurance companies, by directly holding that such standing does not matter. 11a.

A. Louisiana's Preferred Provider Organization Enabling Statute

1. *The Overall System*

As part of its effort to assure access to quality health care services, to preserve patient choice, and to control health care costs, (see La. Rev. Stat. 40:2201), Louisiana enacted a Preferred Provider Organization (PPO) statute authorizing the formation of preferred provider organizations, La. R.S. 40:2201(C), within Title 40 of its Revised Statutes, entitled Public Health and Safety. The Louisiana Legislature declared at La. R.S. 40:2201(2), that it enacted the statute to meet federal standards and regulations. Thus, the Attorney General sought in good faith, to enforce the statute. He did not seek to defy federal law, unlike the Attorney General of *Ex parte Young*.

The legislature defined at La. R.S.40:2202, certain terms among which are those pertinent to this matter. It defines a PPO as a contractual agreement between a health care provider and a group purchaser to provide for alternative rates of payment in which the provider agrees to accept the alternative rate and the agreement may also provide incentives to the insured employee to utilize the participating providers. La. R.S. 40:2202(5)(a),(b). Notably, it characterizes an employee who will utilize the participating providers as "insured."

The statute further defines group purchasers as entities which contract with providers (health care)[see La. R.S.

40:2202(6)] for the purpose of establishing a PPO and may include entities which contract for the benefit of their insured, or self-funded organizations or entities which serve as brokers for the formation of such contracts, including third party administrators like CIGNA and CGLIC. La. R.S. 40:2202(3). Thus, the statute does not state specifically that it "applies to" ERISA plans, an important distinction.

The statute provides in its specific authorization for PPOs provision, La. R.S. 40:2203, that any group purchaser may contract with any provider in any contractual agreement to form a PPO. It also provides that group purchaser members participating in PPOs shall be guaranteed access to their standard benefits under the terms of their policy, or self funded organization benefits, regardless of whether they choose a preferred provider or a provider who does not participate in the preferred provider contract. The remainder of the statute is devoted to regulation of hospital tangible benefits and peer review committees for health care providers.

2. The Any Willing Provider Provision

As part of the state's regulation of this contract between health care providers and health care group purchasers, the statute provides that no licensed provider, other than a hospital, who agrees to the terms of the PPO contract shall be denied the right to offer health care services within the limits of his license. La. R.S. 40:2202(5)(c). The Legislature implemented this provision to achieve its stated goal of protecting the quality of care received by patients and enhancing the ability of health care providers to maintain, update, and expand their facilities to serve their patients and communities and to meet federal and state standards and regulations. La. R.S. 40:2201(A)(1), (2). It is this section of the PPO statute which plaintiffs-respondents sought to invalidate.[3]

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[3]Neither this provision nor the entire statute relates to ERISA plans because the statute and its provision are laws of general applicability which neither single out ERISA plans for special treatment nor are predicated upon the existence of plans and as such have only a tenuous, remote or peripheral connection to employee benefit plans, which have never been held to trigger ERISA preemption. *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, 583, n. 1 (1992).

This contractual requirement operates without regard to whether the group purchaser is or is not a group purchaser for an ERISA plan. The requirement established does not depend upon ERISA status. It operates regardless of whether the contract will be purchased by an ERISA plan. Thus, it is neither predicated upon the existence of ERISA plans nor singles them out for special treatment.

In addition, the challenged Louisiana statute does not restrict any choice that an ERISA plan may have as to form of coverage—self-insured, or commercially insured. It also does not restrict a plan from choosing to cover, in whole or in part, particular kinds of benefits, nor does it require or restrict plans from choosing to purchase a PPO contract from CIGNA or CGLIC. It simply gives ERISA plans the *right* to purchase a contract should they so *choose* and ensures that when they do so, the group members shall be guaranteed access to their standard benefits under their policies or plans regardless of whether they choose a preferred provider or not. La. R.S. 40:2203(C).

B. The Doctrine of Ex parte Young

(I) The Fifth Circuit's Rationale

The Fifth Circuit held that the *Ex parte Young* exception operated to overcome Louisiana's Eleventh Amendment immunity. Plaintiffs-respondents in this case named the State of Louisiana as defendant and sued the State through its Attorney General. Only in the body of the complaint did they assert that they sued the Attorney General in his official capacity. According to plaintiffs-respondents themselves, they could have chosen to sue a variety of persons which they listed in their petition, with the same end result. The Fifth Circuit justified the use of the exception on the ground that an Eleventh Amendment argument was "patently without merit" because it is "well established that the federal courts have jurisdiction to hear suits against state officials where, as here, the plaintiffs seek only prospective, declaratory or injunctive relief to prevent a continuing violation of federal law."

The Court cited a footnote to *Shaw v. Delta Air Lines, Inc.*,[4]

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[4]463 U.S. 85, 96 n. 14, 103 S.Ct. 2890, 77 L.Ed. 2d 490 (1983).

and two of its own cases as authority. In so relying, the Fifth Circuit ignored this Court's abundance of relevant precedent and based its decision on precedent contradictory to that of this Court.

In one of the very cases upon which it relied to deny Louisiana sovereign immunity, the Court itself expressed confusion over the operation of sovereign immunity and the *Ex parte Young* exception by stating in its own words in a dissertation covering numerous pages, that given all of these curious inconsistencies, it is no wonder that lawyers and judges are still confused about the Eleventh Amendment and the doctrine of *Ex parte Young*.[5] The Court further opined at page 1252 of that case, that although the Supreme Court *has sometimes implied otherwise* (emphasis added), *Ex parte Young* is a gaping hole in the shield of sovereign immunity created by the Eleventh Amendment and the Supreme Court. [In other words, the doctrine of *Ex parte Young* is not narrow and may be applied expansively, whenever a lower court so decides, contrary to a profusion of Supreme Court guidance.]

In contrast, however, the *Ex parte Young* exception presents the question of the constitutional validity of a statute because the penalties which it inflicts are so great as to prevent recourse to the courts for the adjudication of respondent's rights under it. (ie., irreparable harm)[6]

In the case at bar, the penalty of the statute is not so great as to prevent recourse to the courts, state or federal, naming a different defendant. (The *Ex parte Young* Court held that the exception was necessary "when the penalties for disobedience are by fines so severe as to intimidate the company from resorting to the courts to test the validity of the legislation." No such severe penalties appear in this civil statute. It provides no terms of incarceration nor penalty provisions of any kind).[7] As proof, plaintiffs-respondents did not even pray for a temporary

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[5]*Brennan v. Stewart*, 834 F.2d 1248, 1251-1255 (5th Cir. 1988).

[6]*Beal v. Missouri Pac. R.R. Corp.*, 312 U.S. 45, 51, 61 S.Ct. 418,421, 85 L.Ed. 577 (1940)

[7]*Ex parte Young, infra*, at 209 U.S. 147, 28 S.Ct. 449.

restraining order as authorized pursuant to Rule 65 (b) of the Federal Rules of Civil Procedure, relief which they surely would have prayed for had their cause arisen to the level of a true *Ex Parte Young* exception. Instead, plaintiffs-respondents were content to allow their case to rest in court for nine months before any adjudication at all was addressed.

(ii) Brief Summary of This Court's Ex parte Young Cases

Unlike the facts in the case at bar, the *Ex Parte Young* Court carved its exception[8] to remedy a situation in which Missouri's attorney general *openly defied* a federal *court order* of injunction by acting contrary to that order. The United States District Court placed the attorney general in prison for contempt of court and the case was brought to court on petition for a writ of habeas corpus. In addition, the suit voiced *Fourteenth Amendment* complaints and the state statute, which carried substantial *imprisonment* and pecuniary *penalties*, imposed *criminal sanctions*. The *Ex Parte Young* Court itself warned that an intolerable situation would arise if *persons* were allowed to *freely contest a state statute's validity* by a proceeding in federal court whenever they were about to be charged with its violation.[9] Thus, this Court has held on many occasions, that the doctrine of *Ex Parte Young* is narrow and is not to be applied expansively. [10]

The facts of the case at bar simply do not fit those of *Ex parte Young*. By sharply departing from the facts of *Ex parte Young* and applying its draconian remedy against the State of Louisiana, the Fifth Circuit has allowed the very same intolerable situation, warned of by the original Court to arise in the case at bar.

In stark contrast to the 5th Circuit's decisions, this Court has consistently held that a presumption against preemption exists in the law.[11] *And significantly*, this Court recently held that even when the Constitution vests in Congress complete law-making

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[8]209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908).

[9]*Ex parte Young* at 209 U.S. 156, 28 S.Ct. 453.

[10]*Edelman v. Jordan*, 415 U.S. 651, 665, 94 S.Ct. 1347, 1357, 39 L.Ed.2d 662 (1972); *Pennhurst, cited infra*, at pgs. 465 U.S. 102, 104 S.Ct. 909.

[11]*New York Blue Cross v. Travelers, infra*, at 115 S.Ct. 1676.

authority over a particular area, (ie., the preemption issue), the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States;[12] a general authorization for suit in federal court does not suffice. The Fifth Circuit's rule of law expressed in *Brennan v. Stewart, supra,* (grant jurisdiction on allegations and try the case to determine if state officials broke federal law) cannot withstand scrutiny in light of the legal precedent set by this Court, because that rule allows a federal court to decide on allegations, without the proof present in *Ex parte Young,* and previous to trial, in order to grant jurisdiction, that a state officer violated federal laws by enforcing in good faith, a statute presumed to be constitutional, conduct startlingly unlike that punished in *Ex parte Young, an extraordinary case.* Such a rule cannot be reconciled with the Constitution. *And,* ERISA, like the Indian Gaming Regulatory Act (IGRA) discussed in *Seminole,* provides a comprehensive scheme for regulation which does not include a congressional intent to abrogate the states' Eleventh Amendment rights, nor is such an intent expressed in the Declaratory Judgment Act. Moreover, the Fifth Circuit expressly declined to follow *Seminole. See* A4, FN1.

In addition, this Court recently held that the real party in interest in an official-capacity suit is the governmental entity and not the "named" official.[13] Further, this Court has held on many recent occasions that unless a State has waived its Eleventh Amendment immunity or Congress has overridden it, a State cannot be sued directly in its own name *regardless of the relief sought.*[14]

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[12]*Seminole Tribe of Florida v. Florida,* _ U.S. __, 116 S.Ct. 1114, 1131, 134 L.Ed.2d 252 (1996).

[13]*Hafer v. Melo,* 502 U.S. 21, 25, 112 S.Ct. 358, 361, 116 L.Ed.2d 301 (1991); *Kentucky v. Graham,* 473 U.S. 159, 166, 105 S.Ct. 3099, 3105, 97 L.Ed.2d 114 (1985).

[14]*Alabama v. Pugh,* 438 U.S. 781, 98 S.Ct. 3057, 57 L.Ed.2d 1114 (1978)(per curiam); *Florida Dept. Of State v. Treasure Salvors, Inc.,* 458 U.S. 670, 684, 102 S.Ct. 3304, 3314, 73 L.Ed.2d 1057 (1982); *Cory v. White,* 457 U.S. 85, 91, 102 S.Ct. 2325, 2329, 72 L.Ed.2d 694 (1982); *Pennhurst State School & Hospital v. Halderman,* 465 U.S. 89, 101-102, 104 S.Ct. 900, 908-909, 79 L.Ed.2d 67 (1984); *Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, Inc.,* 506 U.S. 139, 144, 113 S.Ct. 684, 687-688, 121 L.Ed.2d 605(1993); *Welch v. Texas Dept. Of Highways and Public Transportation,* 483 U.S. 468, 480, 107 S.Ct. 2941, 2949-2950, 97 L.Ed.2d 389 (1987).

In addition, as in the case at bar, when a plaintiff names the state itself as a defendant, a suit against state officials that is in fact a suit against the state is barred regardless of whether it seeks damages or an injunction.[15] and when a state legislature adopts legislation, its actions constitute those of the State.[16] Equally important, a state statute may be enjoined only if it is unconstitutional on its face.[17] Thus, both lower courts should have barred this federal suit against the State of Louisiana by private parties.

C. Decisions Below

1. *District Court*

Respondents CIGNA and CGLIC initially commenced a civil action against the State through its Attorney General on July 19, 1994, seeking, *inter alia*, a declaratory judgment invalidating Louisiana's Any Willing Provider provision under ERISA, through the Declaratory Judgment Act, the Supremacy Clause of the United States, and the Fourteenth Amendment and an injunction against enforcement of the statute.

Ironically, while the District Court dismissed respondents' Fourteenth Amendment claim on April 17, 1995, it granted respondents' motion for summary judgment on the ERISA preemption issue, and, failing to note the extraordinary nature of the doctrine of *Ex parte Young*, expansively and routinely enjoined Richard P. Ieyoub, in his official capacity as the Attorney General of Louisiana, from bringing suit against plaintiffs for alleged violations of La. R.S. 40:2202(5)(c), from issuing a Notice of R.S. 51:1401 Complaint letter and from applying advisory opinion No. 92-824, issued February 8, 1993, as if the State of Louisiana were an ordinary litigant.

The Court reaching the merits of the case, after holding in a foot note that the State's defenses under the Eleventh

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[15]*Cory v. White*, at 457 U.S. 91, 102 S.Ct. 2329; *Pennhurst State school & Hospital v. Halderman*, at 465 U.S. 101- 102, 104 S.Ct. 908-909.

[16]*Parker v. Brown*, at 317 U.S. 352, 63 S.Ct. at 314; *Hoover v. Ronwin*, 466 U.S. 558, 567-568, 104 S.Ct. 1989, 1995, 80 L.Ed.2d 590 (1984).

[17]*Rice v. Norman Williams Co.*, 458 U.S. 654, 659, 102 S.Ct. 3294, 3298-3299 (1982).

Amendment were patently without merit, held that the statute impacted the employers' or *plan sponsors'* discretion as to how health benefits may be structured under their employee benefit plans and also held that the statute 'related to' employee benefit plans, employing the decision of the Fourth Circuit Court of Appeals in *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, cert. denied, 114 S.Ct. 579 (1993) as its ground. However, ironically, in contrast to the appellate court's decision in *Stuart Circle*, the District Court concluded that ERISA's saving clause did not save Louisiana's statute from preemption. As a direct result of this decision, the main thrust of ERISA, the avoidance of a multiplicity of regulation, has been frustrated.[18]

2. Court of Appeals

On April 30, 1996, the Fifth Circuit issued its decision affirming the District Court's holding that the Eleventh Amendment did not bar this suit and that ERISA preempted Louisiana's Any Willing Provider Statute, again frustrating the main thrust of ERISA. The Court held that even though the State was named as defendant through its Attorney General, and the suit was one against a state official in his official capacity, Louisiana's Eleventh Amendment claim was patently without merit and found that the statute both referred to ERISA plans and had a connection to ERISA plans. The Court reasoned that the statute prohibited those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider and as such connected with ERISA plans. It specifically rejected this Court's recent holding regarding indirect economic influence, in the *Travelers* case,[19] by reasoning that the holding was limited, and refused to follow the reasoning of the Fourth Circle in *Stuart Circle*, cited above, which held the Virginia statute saved from preemption. The Court further held that the statute was not saved from preemption because it did not meet the third factor of the *Metropolitan Life* test, cited above. On June 4, 1996 the Court also denied the state's petition for rehearing.

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[18]*New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995).

[19]*Id.*

REASONS FOR GRANTING THE WRIT OF CERTIORARI

This decision warrants review for several reasons. First, insofar as the Fifth Circuit found that the statute was not saved from preemption under ERISA, it put itself in direct conflict with a decision of the Fourth Circuit, holding a virtually identical provision of Virginia law not preempted by ERISA. *See Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, cert. denied, 114 S.Ct. 579 (1993). In rejecting the challenge to Virginia's "any willing provider" provision, the Fourth Circuit held that ERISA did not preempt the state's "Any Willing Provider" provision because it was saved from preemption by ERISA's saving clause.

Second, this ERISA preemption issue and the issue of the expansion of the doctrine of *Ex parte Young* are of considerable importance to all states. The Fifth Circuit barred Louisiana from exercising the regulatory authority allowed to its sister states, Virginia, and Texas. Furthermore, all states are placed in the quandary of not knowing whether—or in what manner—they can carry out traditional police powers of regulating health care provider services. The result seriously impedes patient choice and a provider's right to earn a living. In addition, by ignoring this Court's precedent, this decision set its own precedent that places all States and their Officers in the dilemma of not knowing whether whenever they might enforce a state statute against a private plaintiff, that private party might at any time file a declaratory and injunctive complaint for a speedy judicial determination of questions of constitutional law in federal court, a mode of relief which is inconsistent with the Eleventh Amendment.

Third, the Fifth Circuit's decision expands both preemption and the abrogation of Eleventh Amendment rights beyond reasonable bounds. The Louisiana law is indisputably a law of general application that makes no distinctions whatsoever with respect to ERISA plans. To the extent that ERISA plans may have an incentive to choose a PPO, they stand in exactly the same footing as everyone else. The Louisiana law does not relate to ERISA plans because it is a health care law which regulates the substantive terms of a contract of insurance, with mandatory-provider

regulations, conceptually similar to the mandatory-benefit health care law declared, by the *Metropolitan Life* Court, a law regulating insurance and consequently not preempted by ERISA. *(See Metropolitan Life Insurance Co. v. Massachusetts Travelers Ins. Co., and Stuart Circle*, cited above). The Louisiana law only "relates to" ERISA plans—in the words of the ERISA preemption provision—only in the sense that *any* general law regulating PPOs "relates to" a plan: that is, by subjecting the plan to burdens and benefits like others similarly situated. That has not been, and should not be grounds for preemption of state law. *See Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988).

Similarly, the Louisiana statute does not impinge upon the objectives of ERISA by mandating employee benefit structures or benefits in the sense required for pre-emption, does not provide alternate enforcement mechanisms, does not operate to "effectively restrict" the choice of policies available in the market, is not predicated upon the existence of ERISA plans, but rather regulates a contract of healthcare insurance.

Further, the *extraordinary* remedy created by the doctrine of *Ex parte Young* should not be applied expansively and routinely by federal courts against the states to determine if the officers of the sovereign states "are violating federal law." (In *Ex parte Young*, Missouri's attorney general was jailed for contempt of court at the beginning of the action). Recent precedent set by this Court holds that, even in preemption issues in areas where Congress has legislated exclusively, it did not intend to abrogate the States' Constitutional right guaranteed by the Eleventh Amendment. If Congress did not intend such a result, the Fifth Circuit upset the Constitutional balance of power by usurping Congress' powers in this matter. By expressly declining to follow this precedent and allowing a suit against Louisiana by private parties in this preemption case, both lower courts rendered the Eleventh Amendment meaningless.

Fourth, the Fifth Circuit's decision directly conflicts with prior precedent and relevant decisions of this Court. It conflicts with the cases referenced in the third reason, as well with the *New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co, supra*, and *Seminole Tribe of Florida v. Florida, supra*, (even when the

Constitution vests in Congress complete law-making authority over a particular area, the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting states) and other relevant Eleventh Amendment cases (discussed, supra, in the summary of the *Ex parte Young* cases) which have set forth the principles that a suit against a state in its own name is barred regardless of the relief sought, that suits against a state officer in his official capacity are suits against the state, the exception of *Ex parte Young* is not be applied expansively and Congress must express intent to abrogate states' Eleventh Amendment rights in the body of the statute. (*Blatchford v. Native Village of Noatak*;[20] *Atascadero State Hospital v. Scanlon*).[21] Congress has not expressed an intent to abrogate those rights in either ERISA or the Declaratory Judgment Act, under which this suit was brought. A general authorization for suit in federal court does not suffice.

I. A DIRECT CONFLICT EXISTS BETWEEN TWO CIRCUIT COURTS ON AN ISSUE OF CONSIDERABLE IMPORTANCE

A. Conflict Between Two Circuits

The decision of the Fifth Circuit in this action is in direct conflict with the Fourth Circuit's decision in *Stuart Circle, supra*. While the Fifth Circuit held that ERISA *preempts* Louisiana's "any willing provider" statute, the Fourth Circuit held that ERISA *did not* preempt Virginia's similar law. The Fifth Circuit's decision reflects the narrow reading of the saving clause rejected by this Court in *Metropolitan Life*, by distinguishing between insurance laws and health care laws.[22] For all intents and purposes, the any willing provider provision under Louisiana law is indistinguishable from the Virginia law, given that they both mandate that no provider willing to meet the terms and conditions of the contract

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[20]501 U.S. 775, 779, 111 S.Ct. 2578, 2581, 115 L.Ed.2d 686 (1991).

[21]473 U.S. 234, 238-239, 105 S.Ct. 3142, 3145, 3146, 87 L.Ed.2d 171 (1985).

[22]*Metropolitan Life*, 471 U.S. at 746, 105 S.Ct. at 2393 (Nothing in the language, structure, or legislative history of the Act supports this narrow reading of the clause).

shall be excluded. Further, both statutes regulate the relationship between insurer and insured. In addition, in both statutes, an insurer has considerable latitude in determining the manner in which it selects a preferred provider for its preferred provider organization. Neither section defines "terms and conditions" but rather implies that such terms are variable and dependent upon the specific context in which a PPO is established. The results in the two cases are thus irreconcilable.

Essentially, the two Courts reached these conflicting results due to diametrically opposed analyses of the significance under ERISA of an economic and administrative impact upon ERISA plans and analysis under the "common sense" definition of insurance, utilizing the *Metropolitan Life factors*. (However, while the Virginia statute does not mention ERISA plans in any way, the Louisiana statute provides that ERISA plans may utilize PPOs). The Fifth Circuit noted the Fourth Circuit's decision, and followed it insofar as it found that the Louisiana statute "related" to ERISA, but declined to follow its analysis regarding the *Metropolitan Life* factors.

The Fifth Circuit held that Louisiana's statute related to ERISA plans and was not saved from preemption by ERISA's saving clause because it failed to meet the third prong of the *Massachusetts Life* test by specifying that it "applies" to self-funded and other organizations. 15a. In contrast, the test for preemption ... is whether the existence of ERISA plans is necessary for the statute to be meaningfully applied.[23] In *Greater Washington Bd. of Trade*, the Court preempted statutes which could not be meaningfully applied without reference to ERISA plans. Here, the Louisiana statute would function in exactly the same way even if ERISA plans did not provide health care coverage as a benefit or even if they did not choose to utilize PPOs.

According to the Fifth Circuit, regardless of whether the self-funded plan has a choice of whether to utilize an insurer's PPO, the statute is unconstitutional on its face because "it applies" to self-insured plans and in turn, specifically mandates

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[23]*Greater Washington Bd. Of Trade*, supra, at 113 S.Ct. 583-584; *NYS HMO Conference v. Curiale*, 64 F.3d 794, 800 (2nd Cir. 1995).

that certain benefits available to ERISA plans must be constructed in a particular manner,[24] which in turn does not merely raise the cost of the implicated benefits; it also delineates their very structure. Similarly, the Court found that the fact that neither CIGNA nor CGLIC (plaintiffs-respondents) is itself an ERISA plan was inconsequential to the issue of standing and found HMOs and insurers to be within the same class of ERISA protection as employers. 8a, FN18, 11a.

On the other hand, while the Fourth Circuit acknowledged this Court's rationale in *Metropolitan Life* that mandatory-provider regulations were conceptually similar to the mandatory-benefit law, [found not related to ERISA], it nevertheless found it necessary to hold the law *saved* from preemption on the basis of *Metropolitan's* test. In its case, the Fourth Circuit rejected the District Court's reasoning that the Virginia statute affected ERISA plans by regulating the structure of an insurer's PPO, (the reasoning affirmed by the Fifth Circuit). The Fourth Circuit reasoned that the statute applied to plans because it had a provision relating to benefits which an insured may receive from an insurer's PPO and restricted the ability of an insurance company to limit the choice of providers that otherwise would confine the participants of an employee benefit health plan to those preferred by the insurer, regardless of whether the participant could select a provider outside the plan, albeit at the expense of forfeiting some of his benefits; however, notwithstanding, the Court held that the law was *saved* from preemption by the saving clause.

It is difficult to see how the Fifth Circuit found, when there exists a strong presumption against preemption, that it was Congress' "clear and manifest intent" to preempt the Louisiana law, given that it was enacted at least ten years after ERISA and was designed to regulate the recent use by managed care of programs of restricted health care provider networks. Obviously, Congress could not in 1974 when it passed ERISA have had a "clear and manifest" intent to prohibit state regulation of a health

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[24](ERISA does not regulate the substantive content of welfare-benefit plans). *Metropolitan Life*, 471 U.S. at 732, 105 S.Ct. at 2380; *Shaw v. Delta Airlines*, at 463 U.S. 91, 103 S.Ct. 2896-2897.

industry business practice that had not yet emerged and that was only indirectly related to ERISA plans. On the contrary, Congress warned that entrepreneurs with a profit motive would try to assert that their plans were ERISA plans, but that they were no more ERISA plans that any other type of insurance.[25] *And*, Congress did not intend to preempt areas of traditional state regulation. In the same vein, it is difficult to see how the Court found that the Louisiana law related to ERISA plans given that the *Metropolitan Life* Court previously held that health care laws regulating contracts of insurance were insurance laws not requiring salvation from preemption.

Beyond this, the Fifth Circuit found, that a statute must both fit the common sense definition of insurance regulation and the Court must answer "yes" to each of the questions in the three part *Metropolitan Life* test to escape ERISA preemption, relying on its own decision. 14a,[26] which encompassed litigation between the primary ERISA parties. In contrast, this Court moved away from rigid application of the McCarran-Ferguson Act criteria in *United States Department of the Treasury v. Fabe*, 113 S.Ct. 2202 (1993) and the so-called common sense definition of insurance regulation is essentially equivalent to one of the prongs of the three-part *Metropolitan Life* test.[27] Furthermore, none of the three criteria is, by itself, determinative.[28]

Moreover, this Court has never expressly required the application of the McCarran-Ferguson "business of insurance" test to ERISA saving clause issues. Indeed, its opinion in *Metropolitan Life* merely noted that the business of insurance analysis *also sup-*

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[25]*MD Physicians & Associates, Inc.*, cited *infra*, at page 184.

[26]*Tingle v. Pac. Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993).

[27]Compare the common-sense definition as set forth in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 1554, 95 L.Ed.2d 39 (1987) [to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry] with the third factor of the *Metropolitan Life* test at 105 S.Ct. 2391, (whether the practice is limited to entities within the insurance industry).

[28]*Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

ported its conclusion that the statute at issue regulated insurance.[29]

In particular, this Court has previously and unequivocally held that a health care law which regulates a contract of insurance is not pre-empted by ERISA,[30] and that it is both historically and conceptually inaccurate to assert that mandated-benefit laws are not traditional insurance laws, those laws being only one variety of a matrix of state laws that regulate the substantive content of health-insurance policies to further state health policy.[31]

B. Issues of Considerable Importance

The issue that divides the Fourth and Fifth Circuits is of great significance to a state's ability to exercise a fundamental state police power—the regulation of health care, balancing the control of its costs without jeopardizing quality of care received by patients and the ability of health care providers to maintain, update, and expand their facilities to serve their patients and communities. *See e.g., Hillsborough Count v. Automated Medical Lab, Inc.*, 471 U.S. 707, 719 (1985) ("the regulation of health and safety matters is primarily, and historically, a matter of local concern").

Pursuant to its traditional police powers as well as a constitutional mandate to promote the health, safety, education, and welfare of the people of Louisiana, the State has enacted laws designed to foster a fair and efficient system to control health care costs. *See, e.g.*, La. Const. Of 1974, Preamble; La. R.S. 40:2201. This action now threatens Louisiana's ability to achieve these balanced objectives.

Aside from incapacitating Louisiana's effort to keep the system fair for patients and health care providers alike, the Fifth Circuit's decision will incapacitate such efforts of every other state with similar laws. Should a state continue to regulate PPOs in any form, that state not only faces certain litigation, it also

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[29] *Metropolitan Life*, 471 U.S. at 742-744.

[30] *Id.* at pgs. 471 U.S. 741-743, 105 S.Ct. 2389-2391.

[31] *Id.* at pages 729, 2384.

faces potentially crippling liability coupled with a decline in the quality of patient care as well as a decline in the number of health care providers willing to remain in Louisiana as a result of the Fifth Circuit's erroneous decision.

Further, within the State of Texas, a recent court decision upheld[32] an ERISA challenge to its any willing provider provision, which may be overturned by the Fifth Circuit on appeal. Similar litigation is occurring in the State of Massachusetts.[33]

In addition to precluding a state's ability to achieve its own traditional police power objectives, the Fifth Circuit's decision will impede federal constitutional principles of equal protection of the law in that it grants to HMOs and big insurance companies a favored position over the rights of Louisiana citizen-patients and health care providers. Furthermore, the decision runs contrary to the legislative intent of ERISA by placing HMOs and insurers in the same class as employers who establish ERISA covered plans.[34]

Finally, the Fifth Circuit decision gives rise to the broader issue regarding the extent to which states can enact any law regulating the operation of health care providers. The Third Circuit in *United Wire, Metal & Machine Health & Welfare Fund v.*

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[32]*Texas Pharmacy Assoc. v. Prudential Ins. Co. Of America*, 907 F.Supp. 1019 (W.D. TX 1995). (Texas "any qualified provider" statute fell within the insurance savings clause of ERISA and therefore was not preempted).

[33]*American Drug Stores Inc., d/b/a Osco Drug Stores v. Harvard Pilgrim Health Care, Inc. and Prudential Insurance Co. Of America*, (Civil Action No. 96-10084-MEL, MA. District, 1996).

[34]*MD Physicians & Associates, Inc. v. State Board of Insurance*, 957 F.2d 178, 184 (5th Cir. 1992) (entrepreneurs whose primary interest is in profiting from the provision of administrative services through the formation of insurance companies and related enterprises will argue that its enterprise is an ERISA benefit plan which is protected by ERISA's preemption provision. These programs are not 'employee benefit plans; these plans are established and maintained by entrepreneurs for the purpose of marketing insurance products or services to others. They are not established or maintained by the appropriate parties to confer ERISA jurisdiction. Activity Report of the Committee on Education and Labor). (We do not believe that the statute and legislative history will support the inclusion of what amounts to commercial products within the umbrella of the employee benefit plan. H.R. Rep. No. 1785, 94th Cong., 2d Sess. 48 (1977)).

Morristown Memorial Hosp., 995 F.2d 1179 (3d Cir.), *cert denied*, 114 S.Ct. 383 *reh'g denied*, 114 S.Ct. 651 (1993), suggested that if state laws were invalidated due to indirect economic impact, then a host of other state health laws may be preempted because they have some indirect impact on costs. Under the same rationale, any law which has the potential of increasing the insurer's cost of doing business, and accordingly, its billings to plan participants, would be preempted, such as laws providing minimum standards for physician and nurses certification, medical malpractice suits against hospitals and physicians, hospital minimum staffing levels for physicians and nurses, record-keeping requirements, construction codes and infection control procedures could also be preempted. *See, e.g.*, La Revised Statutes, Public Health and Safety, Title 40, and La Revised Statutes, Professions and Occupations, Title 37. Without clear guidance from this Court, this action will likely spawn challenges to these and other fundamental state health laws, seeking to immunize ERISA plans from any costs associated with those laws.

Of equal importance to states is the impact of the Fifth Circuit's denial of Eleventh Amendment immunity to a state and its chief legal officer. The result of this decision, is, in the Fifth Circuits own words, a "gaping hole" in states' Eleventh Amendment immunity, which runs counter to the significant body of case law developed since the *Ex parte Young* decision was rendered. The Fifth Circuit set a dangerous precedent, in sharply departing from the facts of *Ex parte Young* to apply its exception and fell into the very trap[35] against which the *Ex parte Young*

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[35] "If, because they were law officers of the state, a case could be made for the purpose of testing the constitutionality of the statute, by an injunction suit brought against them, then the constitutionality of every act passed by the legislature could be tested by a suit against the governor and the attorney general, based upon the theory that the former, as the executive of the state, was, in a general sense, charged with the execution of all its laws, and the latter, as attorney general, might represent the state in litigation involving the enforcement of its statutes. That would be a very convenient way for obtaining a speedy judicial determination of questions of constitutional law which may be raised by individuals, but it is a mode which cannot be applied to the states of the Union consistently with the fundamental principle that they cannot, without their assent, be brought into any court at the suit of private persons." *Ex parte Young* at 28 S.Ct. 453.

Court warned. Without clear guidance from this Court, this action will likely engender constitutional challenges to a host of other state laws through the states' attorneys general.

Importantly, the Fifth Circuit's rule of law expressed in *Brennan, supra*, cannot survive scrutiny (grant jurisdiction on allegations and try the case to determine if state officials broke federal law). Under this rationale, a federal court may make a decision, on allegations alone and prior to trial, that a state official has broken a federal law, and grant jurisdiction based vaguely, on *Ex parte Young*. Such action is inconsistent with the Constitution of the United States.

II. THE FIFTH CIRCUIT WRONGLY EXPANDED THE SCOPE OF ERISA PREEMPTION

This case represents the first time a Circuit Court decision can be read to hold that a law of general application, mandates employee benefit structures simply because it has an indirect economic impact on ERISA plans, when and if, the plans choose to utilize the benefits of the statute by purchasing a specific contract for health services, a PPO contract. If this Court sustains this interpretation, ERISA plans will lead a "charmed existence that was never contemplated by Congress." *United Wire*, 995 F.2d at 1194, *quoting Rebaldo*, at 138-39. Moreover, it represents the first time a Circuit Court decision can be read to hold that a health care law is not an insurance law and therefore, relates to ERISA plans. (This Court previously held that a health care law cannot be distinguished from an insurance law in *Metropolitan Life*).

While Louisiana Revised Statutes Public Health and Safety Law section 2202(3), defines ERISA plans as among those purchasers who may purchase a PPO contract, it neither specifically applies to ERISA plans, unless the plans choose to purchase such contract, nor is it predicated upon the existence of ERISA plans. To the contrary, it applies to a contract between health care purchasers and providers to provide health care services (an insurance contract), irrespective of ERISA plans. In its definitional section, La. R.S. 40:2202(3)(a), for example, it merely provides a definition of group purchaser which, as an example, may include self-funded insurers, giving them a choice. It does not require

that self-funded insurers purchase such a contract. It also names a variety of other organizations who may purchase the contract. It does not single out ERISA plans for special treatment. Section 2202(3)(b) defines group purchasers as entities which serve as *brokers for the formation of such contracts* as intermediaries, including examples.

Significantly, these provisions speak to group purchasers of a contract between them and health care providers, and not to ERISA benefits for ERISA plan participants and beneficiaries. The provisions do not restrict an ERISA plan from determining its form or level of benefits. ERISA plans are free to self-insure, join an HMO, or insure through commercial insurance. And, regardless of the funding method, an ERISA plan is free to set the terms and conditions of the contract. *See*, La. R.S. 40:22025(c).

The Fifth Circuit failed to consider the ruling in *Metropolitan Life*, at 105 S.Ct. 2389-2391, which made it clear that health care laws are insurance laws, that *do not relate* to benefit plans in the first place, and therefore do not need to be saved from preemption.

At most, the Louisiana law has an indirect economic impact, that affects ERISA plans in the same manner as it affects other consumers and providers of health insurance. This indirect impact is simply insufficient to justify preemption. Otherwise, ERISA plans would be exempt from any state regulation that indirectly affects the cost of doing business, including rent control laws, labor laws and highway tolls.

As recognized by the Third Circuit in *United Wire*, this court already has rejected such an expansive approach to ERISA preemption. In *Mackey*, this Court ruled that ERISA did not preempt the application of a state garnishment statute to ERISA plans even though it created substantial costs to such plans. This finding is wholly in accord with this Court's long-standing principle that ERISA does not preempt state laws that have "only a 'tenuous, remote, or peripheral' connection with covered plans ... as is the case with many laws of general application."[36]

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[36]*Greater Wash. Bd. of Trade, supra*, at 113 S.Ct. 583 n.1, *quoting Shaw v. Delta Air Lines, supra.*

Equally important, the Fifth Circuit failed to consider whether Congress intended for ERISA to preempt generally-applicable state health care laws, in particular. This failure is contrary to a line of Supreme Court cases, the latest of which is *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, supra, at 115 S.Ct. 1666-1667, that establish Congressional intent as the "ultimate touchstone" in any pre-emption analysis. *E.g. Cipollone v. Liggett Group*, 112 S.Ct. 2608, 2617 (1992), *quoting Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978). This line of cases applies the preemption doctrine cautiously to prevent federal laws from intruding onto traditional state police powers, absent compelling evidence of Congressional intent. *E.g., Rice v. Santa Fe Elevator Corp., supra*, at 331 U.S. 230. (preemption analysis "starts with the assumption that the historic police powers of the States [are] not to be superseded ... unless that [is] the clear and manifest purpose of Congress"); *Alessi v. Raybestos-Manhattan, Inc*, 451 U.S. 504, 522 (1981) (the need for unmistakable Congressional intent is "guided by respect for separate spheres of governmental authority preserved in our federalist system").

Given these cases and the Congressional intent reported by the 5th Circuit in *MdPhysicians, supra*, this decision cannot stand because it operates in contradiction to Congressional intent. In determining whether Congress intended to preempt state regulation of health care costs and charges, it is necessary to examine what Congress has said, and legislated, on both employee benefits and health care. *United Wire and Metropolitan Life* undertook such a dual analysis; the decision below did not. Moreover, the Fifth Circuit undertook such an analysis of Congressional intent itself in *Mdphysicians, supra*, which contradicts its decision in this matter. While paying heed to Congress' intent to broadly pre-empt state laws under ERISA, the Fifth Circuit simply ignored twenty-five years of Congressional legislation and encouragement of state efforts to regulate health care.

Although these tests have never been mandatory, even if this Court finds that the statute "relates to" ERISA plans unlike the *Metropolitan Life* Court, then, the question would become whether the statute is within the insurance saving clause, and if

its test were to be applied, the correct analysis should have been: (1) the statute meets the common sense definition of insurance regulation because it is clearly designed to regulate insurance contracts, by providing that a PPO shall mean a *contractual* agreement between a provider and a group purchaser', thus it regulates a *contract of insurance*, not ERISA plans; (2)(a) the statute has the effect of spreading the policyholders' cost risk, because it spreads the "cost component of the policyholders' risk among all insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking health care services from an excluded physician of his or her choice; (2)(b) the statute is an integral part of the policy relationship between the insurer and the insured because it ensures that all policyholders have the option of visiting a qualified health care provider of his or her choice without paying an increased cost for that option; thus, it does not distinguish and set apart ERISA plans for special treatment, but, instead is even-handed in its application toward consumers, like the statute in the *Travelers* case, supra; It only has the potential effect of increasing the cost of business for HMOs and insurance companies, that sell PPOs, founded by entrepreneurs, whose main intent is profit; (2)(c) it satisfies the third factor, by limiting its effect to entities within the insurance industry because, the any qualified provider statute imposes requirements only on the insurers, with the intent of affecting the relationship between the insured and the insurer, through a contract of insurance to provide health care services.

III. THE FIFTH CIRCUIT WRONGLY EXPANDED THE SCOPE OF EX PARTE YOUNG

The Fifth Circuit's finding that the exception of *Ex parte Young* abrogates Louisiana's and its Attorney General's sovereign immunities suffers from the same faulty reasoning employed in its ERISA analysis, ie., an unwarranted expansion of legal principles, and an encroachment into the police powers of the state. Despite this case's dissimilarity from traditional *Ex parte Young* and Eleventh Amendment analysis, the Fifth Circuit has taken a novel approach to a state's Eleventh Amendment immunity and the *Ex parte Young* exception, one not supported by the case law.

In its analysis, the Fifth Circuit's decision conflicts with and ignores, the large body of case law developed by this Court regarding the exception, including its most recent decision in *Seminole Tribe of Florida, v. Florida, supra,* which the Fifth Circuit expressly found did not apply to the circumstances of this matter. 4a, FN1. The uncertainty created by the Fifth Circuit's ruling on sovereign immunity is appropriate for resolution by this Court. For the following reasons, this ruling is also erroneous.

The Fifth Circuit's decision reflects its own principle of law, 3a, FN1, (*see Brennan v. Stewart, supra and infra*) that a federal court may determine in *advance of trial* that a state officer has violated federal law sufficient to confer jurisdiction based upon the doctrine of *Ex parte Young,* without legal analysis of the doctrine. Given this Court's strong legal presumption against preemption, this legal philosophy is inconsistent with the Constitution.

More specifically, this Court has recently expanded this line of thinking by holding in *Seminole,* its most recent expression of the law, that "we have often made it clear that the *relief* sought by a plaintiff suing a State is *irrelevant* to the question whether the suit is barred by the Eleventh Amendment,[37] and that even when the Constitution vests in Congress complete law-making authority over a particular area, (preemption), the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States;[38] ie., even in preemption cases, the Eleventh Amendment bars suits against the state. These mandates should have guided the Fifth Circuit. It should have barred private entrepreneurs from hauling this unconsenting state into court against its will under the guise of the *extraordinary* doctrine of *Ex parte Young* and through the vehicle of the Declaratory Judgment Act in light of this court's instruction in *Seminole Tribe* at 116 S.Ct. 1123, quoting *Atascadero State Hospital v. Scanlon, supra,* (A general authorization for suit in federal court is not the kind of unequivocal statutory language sufficient to abrogate the Eleventh Amendment).

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[37] *Seminole Tribe* at 116 S.Ct. 1124.

[38] *Id.* at 116 S.Ct. 1131.

Instead, the Fifth Circuit distinguished *Seminole* and dismissed Louisiana's Eleventh Amendment immunity, without any meaningful analysis, disregarding the facts that plaintiffs' 14th Amendment claims were dismissed and not appealed, that the action was not based upon a criminal statute with intimidating provisions and penalties, that Louisiana's Attorney General acted in good faith in attempting to enforce the statute which is an act of the state's legislature, the Attorney General did not defy a federal court order, the suit was not a habeas corpus action, and, neither the Declaratory Judgment Act nor ERISA, abrogate the states' constitutional immunities.

The Fifth Circuit itself, expressed confusion regarding the exception of *Ex parte Young*, in *Brennan v. Stewart*,[39] its own authority and one upon which it relied in making its ruling. It opined that, "(a) federal court always has jurisdiction of a suit seeking to enjoin state officials from violating federal laws. If the officials are not violating federal law, judgment should be entered for the defendants on the merits;"(Emphasis supplied); (ie., the doctrine of *Ex parte Young* is *not* narrow and *may be expansively applied*, in direct contradiction of this court's guidance, and falling into the very constitutionally inconsistent analysis warned against by the *Ex parte Young* Court itself). This argument does not survive scrutiny in this matter, given the force of this Court's profusion of guidance to the contrary and its long-standing and strong legal presumption against preemption.

Also, in *Stewart*, the Fifth Circuit read *Pennhurst* to mean that official-capacity actions for prospective relief are not treated as actions against the State, in direct contrast to the case itself, *Cory v. White, supra, Parker v. Brown, supra, and Hoover v. Ronwin, supra.* Furthermore, it expressly stated that "(a)lthough the Supreme Court has *sometimes implied* otherwise, [FN5] *Ex parte Young* is a gaping hole in the shield of sovereign immunity created by the Eleventh Amendment and the Supreme Court." (emphasis supplied). While stating on page 1253-1254, that "(t)he Eleventh Amendment and the doctrine of *Ex parte Young* together create a relatively simple rule of state immunity", it at

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[39] *supra*, at 834 F.2d 1251-1255.

the same time stated, on page 1253, that "the doctrine continues to confound lawyers and judges alike" and that "(a)t least part of the problem is that the Supreme Court shifts between formalistic recitations of Eleventh Amendment dogma without acknowledging *Ex parte Young* even in a footnote and ruling on the merits of dozens of cases under *Ex parte Young* fiction without mentioning the Eleventh Amendment issue even in passing." As examples, the Court cited *Atascadero State Hospital v. Scanlon, supra,* and *Alabama v. Pugh, supra.*

The Fifth Circuit also failed to note that in *Atascadero,* this Court held that Congress' intent to abrogate the States' immunity from suit must be obvious from "a clear legislative statement," (which is not present in either the Declaratory Judgment Act or ERISA).

Later in the case, the Court opined that "given all these curious inconsistencies, it is no wonder that lawyers and judges are still confused about the Eleventh Amendment and the doctrine of *Ex parte Young.* Thus, the Fifth Circuit erroneously relied upon its own case to decide this matter.

Equally important, given the Court's recent ruling in the *Travelers* case, *supra,* that an indirect economic effect on plans is insufficient to support ERISA preemption, and that the issue of preemption turned on Congressional intent, this Court should have proceeded more cautiously than it did, in finding in advance of trial, that Louisiana's Attorney General violated federal laws, on par with the attorney general in *Ex parte Young,* sufficient to abrogate the State's Eleventh Amendment immunity.

Contrary to the Fifth Circuit's ruling, the exception of *Ex parte Young* does not abrogate Louisiana's and its Attorney General's sovereign immunities in this matter when this Court has previously ruled that suits against an officer of the state in his official capacity are suits against the state itself and not against the "named" official,[40] that unless a State has waived its Eleventh Amendment immunity or Congress has overridden it, a State cannot be sued directly in its own name, regardless of the relief

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[40]*Hafer v. Melo, supra; Kentucky v. Graham, supra.*

sought,[41] that even when the Constitution vests in Congress complete law-making authority over a particular area, the Eleventh Amendment prevents congressional authorization of suits by private parties against unconsenting States,[42] that the doctrine of *Ex parte Young* is narrow and not to be applied expansively,[43] that when a state legislature adopts legislation, its actions constitute those of the State,[44] and that a state statute may be enjoined only if unconstitutional on its face.[45]

Notably, *Ex parte Young* involved Fourteenth Amendment issues, (which issues in this matter were dismissed by the District Court and never appealed), and a criminal state statute which carried substantial imprisonment and pecuniary penalties, *and*, was a habeas corpus proceeding to extricate the attorney general from jail where he found himself after violating a federal court order, unlike Louisiana's Attorney General. The present matter fits none of these facts and thus, does not fit within the narrow exception, which is not to be applied expansively.

Similarly, this Court has often held that Congress could in the exercise of its enforcement power under *section 5 of the Fourteenth Amendment*, set aside the States' immunity from retroactive damages.[46] Later, this Court accepted certiorari to resolve numerous conflicts in whether even the Civil Rights Act, 42 U.S.C. 1988, could be enforced against a state. This Court unequivocally held that despite its proximity to the Fourteenth Amendment, such actions could not be enforced against either

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[41] *Alabama v. Pugh, supra, n.9; Florida Dept. Of State v. Treasure Salvors, Inc., supra, n.9; Cory v. White, supra, n.9; Pennhurst State School & Hosp. v. Halderman, supra, n.9; Puerto Rico Aqueduct and Sewer Authority v. Metcalf & Eddy, supra, n.9; Welch v. Texas Dept. Of Highways and Public Transportation, supra.*

[42] *Seminole Tribe, supra.*

[43] *Edelman v. Jordan, supra, n. 11; Pennhurst, supra, n. 11.*

[44] *Parker v. Brown, supra, n. 12; Hoover v. Ronwin, supra, n. 12.*

[45] *Rice v. Norman Williams Co., supra, n. 13.*

[46] *See, Missouri v. Jenkins* 491 U.S. 274, 279, 109 S.Ct. 2463, 2467, 105 L.Ed.2d 229, quoting *Hutto v. Finney*, 437 U.S. 678, 98 S.Ct. 2565, 57 L.Ed.2d 522 (1978) which in turn cited *Fitzpatrick v. Bitzey*, 427 U.S. 445, 96 S.Ct. 2666, 49 L.Ed.2d 614 (1976).

states or state officials, because the word state was not included in the statute, thus, stemming the tide of suits against states and their officials. The *Michigan State Police* Court asserted that this approach is particularly applicable where it is claimed that Congress has subjected the State to liability to which they had not been subject before. This rule has been upheld in all of the Eleventh Amendment cases cited by Louisiana in this matter. Thus, because Louisiana's health care law was not in existence at the time ERISA was enacted, *and* this Court has previously held that health care laws are not insurance laws, the Fifth Circuit should have dismissed this declaratory judgment action against Louisiana and its Attorney General, based upon the lone fact that Congress did not intend to abrogate the states' Eleventh Amendment immunity either in the Declaratory Judgment Act, or in ERISA, not having made this intention unmistakably clear in the language of the Acts.

And, *equally important*, given the force of this Court's long-standing strong legal presumption against preemption, the Fifth Circuit should have prohibited this suit naming the state as defendant and claiming to sue its Attorney General in his official capacity for performing in good faith, the duty conferred upon him by the people of the State of Louisiana in its Constitution, and statutorily, by the State Legislature as well, to enforce all civil laws enacted by it. Thus, the actions of Louisiana's Attorney General, are inextricably bound to those of the State of Louisiana, and this case is in fact, in name and in law, a suit against the sovereign state of Louisiana, which is inconsistent with the Constitution.

CONCLUSION

This case presents a compelling opportunity for this Honorable Court to resolve a conflict among the circuits and, at the same time, to settle two important Federal questions seriously threatening harmonious Federal-State relationships nationwide regarding the doctrine of *Ex parte Young* and yet another ERISA preemption issue which threatens patient choice and the states' rights to regulate health care. The State of Louisiana, through its Attorney General, respectfully requests this Court to grant its petition for a writ of certiorari for the foregoing reasons.

Respectfully submitted,

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*** Counsel of Record**

APPENDIX A

[Filed June 4, 1996]

In the United States Court of Appeals
for the Fifth Circuit

No. 95-30481

CIGNA HEALTHPLAN OF LOUISIANA, INCORPORATED;
CONNECTICUT GENERAL LIFE INSURANCE COMPANY
Plaintiff - Appellees

v.

STATE OF LOUISIANA, ex. rel. Richard P. Ieyoub,
Attorney General
Defendant - Appellant

Appeal from the Untied States District Court for the
Middle District of Louisiana, Baton Rouge

ON PETITION FOR REHEARING

Before REYNALDO G. GARZA, WIENER, and STEWART, Circuit Judges. PER CURIAM:

It is ordered that the petition for rehearing filed in the above case is denied.

ENTERED FOR THE COURT:

s/
United States Circuit Judge

APPENDIX B

[Filed April 30, 1996]

In the United States Court of Appeals
for the Fifth Circuit

No. 95-30481

CIGNA HEALTHPLAN OF LOUISIANA, INC.;
CONNECTICUT GENERAL LIFE INSURANCE CO.,
Plaintiffs - Appellees,

versus

STATE OF LOUISIANA, Ex Rel. Richard P. Ieyoub,
Attorney General,
Defendant - Appellant.

Appeal from the United States District Court
For the Middle District of Louisiana

Before REYNALDO G. GARZA, WIENER, and STEWART, Circuit Judges. WEINER, Circuit Judge:

Plaintiffs-Appellees CIGNA Healthplan of Louisiana (CIGNA) and Connecticut General Life Insurance Company (CGLIC) filed suit against Defendant-Appellant the State of Louisiana, ex rel. Richard P. Ieyoub, Attorney General[1] (Ieyoub),

[1]In their complaint, CIGNA and CGLIC name Ieyoub, acting in his official capacity, as the defendant in this action. Nevertheless, Ieyoub contends that the Eleventh Amendment bars the suit. The district court rejected this argument out of hand, characterizing it as "patently without merit." We agree with the court's assessment of this issue, as it is well established that the federal courts have jurisdiction to hear suits against state officials where, as here, the plaintiffs seek only prospective declaratory or injunctive relief to prevent a continuing violation of federal law. *See. e.g., Shaw v. Delta Air Lines. Inc.*, 463 U.S. 85, 96 n.14, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983); *Saltz v. Tenn. Dep't of Employment Sec.*, 976 F.2d 966 (5th Cir. 1992); *Brennan v. Stewart*, 834 F.2d 1248 (5th Cir. 1988).

seeking *inter alia* (1) a declaratory judgment holding that Louisiana's Any Willing Provider statute[2] is preempted by the Employee Retirement Income Security Act (ERISA)[3]; and (2) an injunction prohibiting the commencement of any action against them for alleged violations of the Any Willing Provider statute.[4] The district court granted summary judgment declaring that ERISA preempts the Any Willing Provider statute insofar as it applies to third party administrators and health care plans that provide services to ERISA-qualified benefit plans, and issued an injunction barring enforcement of the statute against CIGNA and CGLIC. Concluding that the Any Willing Provider statute relates

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Our conclusion is unaffected by the Supreme Court's recent decision in *Seminole Tribe of Florida v. Florida*, 1996 W.L. 134309 (U.S. May 27, 1996) (5-4 decision). There, a sharply divided court held that suits against state officials for prospective injunctive relief are barred "where Congress has prescribed a detailed remedial scheme for the enforcement against a State of a statutorily created right." *Id.* at *16. Here, CIGNA and CGLIC do not seek to enforce against Louisiana any cause of action created by Congress; and no congressionally mandated remedial scheme is implicated. Instead, CIGNA and CGLIC seek only to prevent a Louisiana official from violating the Supremacy Clause of the United States Constitution by encroaching on legal terrain that Congress has properly deemed preempted. Accordingly, the Court's holding in *Seminole* does not apply to the circumstances of this case; and we affirm the district court's determination that the Eleventh Amendment does not proscribe this suit.

The district court also rejected Ieyoub's contention that this action is barred by the Anti-Injunction Act. As the Anti-Injunction Act prohibits a federal court from staying a pending state court proceeding, and as CIGNA and CGLIC seek no such stay, we affirm the district court's holding on this issue. *See, e.g., B & A Pipeline Co. v. Dorey*, 904 F.2d 996, 1001 n.15 (5th. Cir. 1990) (citing *Dombrowski v. Pfister*, 380 U.S. 479, 85 S. Ct. 1116, 14 L. Ed. 2d 22 (1965)).

[2]*See* LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992) ("No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of his license.").

[3]*See* 29 U.S.C.S. §§ 1001 et seq. (Law. Co-op 1990 & Supp. 1995) .

[4]CIGNA and CGLIC also sought declaratory and injunctive relief on the theory that the Any Willing Provider statute violates the Due Process clause of the United States Constitution. The district court dismissed the due process claim for failure to state a claim. CIGNA and CGLIC do not challenge this ruling on appeal.

to employee benefit plans within the meaning of ERISA's preemption clause,[5] and that the statute is not exempted from preemption by ERISA's insurance savings clause,[6] we affirm.

I. FACTS AND PROCEEDINGS

A. FACTS

1. The Any Willing Provider Statute

In 1984, in an attempt to reduce health care costs without jeopardizing the quality of care received by patients,[7] the Louisiana legislature enacted the Health Care Cost Control Act (the Act).[8] The Act specifically authorizes the formation of preferred provider organizations (PPOs), which are defined as "contractual...agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment..."[9] The definitional section of the Act contains a definition of "group purchaser," then follows the definition with an illustrative list of some of the types of entities that may be included in that category.[10] According to the Act, "group purchasers" may include "[e]ntities which contract for the benefit of their

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[5]*See* 29 U.S.C.S. § 1144(a) (Law. Co-op 1990).

[6]*See* 29 U.S.C.S. § 1144(b)(2)(A) (Law. Co-op 1990) (providing that, with limitations irrelevant, the instant appeal, "nothing in this title shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities").

[7]*See* LA. REV. STAT. ANN. § 40:2201(A) (West 1992).

[8]*See* LA. REV. STAT. ANN. §§ 40: 2201 et seq. (West 1992 & Supp. 1996).

[9]LA. REV. STAT. ANN. § 40:2202(5) (West 1992).

[10]Section 2202(3) of the Act reads:

"Group purchaser" shall mean an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization. "Group purchaser" may include:

(a) Entities which contract for the benefit of their insured [sic], employees, or members such as insurers, self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs.

(b) Entities which serve as brokers for the formation of such contracts, including health care financiers, third party administrators, providers, or other intermediaries. *See* LA. REV. STAT. ANN. § 40:2202(3) (West 1992).

insured, employees, or member's[11]; and "[e]ntities which serve as brokers for the formation of [contracts with providers], including health care financiers, third party administrators,...or other intermediaries."[12]

The Any Willing Provider statute, which is incorporated as § 2202(5)(c) of the Act, mandates that "[n]o licensed provider...who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider."[13] According to an advisory opinion issued by the Louisiana Attorney General's office in February 1993, the arbitrary exclusion from a PPO of a licensed physician who is "willing and able to accede to the terms and conditions of the preferred provider contract" constitutes both a violation of the Any Willing Provider statute and an unfair trade practice under Louisiana law.[14]

2. The Parties

Both CIGNA and CGLIC constitute "group purchasers" under the terms of the Act. CIGNA is a licensed health maintenance organization (HMO) that provides prepaid health care coverage to enrolled subscribers—including the sponsors of ERISA-qualified employee benefit plans—by contracting with selected physicians, hospitals, and other health care suppliers (collectively, providers). The chosen providers agree to comply with CIGNA's quality control requirements and to offer health care services to CIGNA's subscribers at a discounted rate.

In Louisiana, CIGNA's provider network is marketed by CGLIC, a licensed health insurer. CGLIC also contracts with CIGNA for the right to use the provider network in conjunction with the insured and self-funded health benefit plans that CGLIC offers to, and administers for, its clients. Like CIGNA's subscribers, CGLIC's clients include the sponsors of ERISA-qualified employee welfare benefit plans.

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[11]LA. REV. STAT. ANN. § 40:2202(3)(a).

[12]LA. REV. STAT. ANN. § 40:2202(3)(b).

[13]LA. REV. STAT. PNN. § 40:2202(5)(c).

[14]*See* Op. Att'y Gen. No. 92-824 (Feb. 8, 1993).

3. Impact of the Any Willing Provider Statute

In 1994, CIGNA notified one of the physicians on its provider network, Dr. Ronald Sylvest, that his contract was being terminated. Dr. Sylvest sued CIGNA, alleging that his termination violated the Any Willing Provider statute. After a temporary restraining order was issued against CIGNA, the parties reached a settlement; and the suit was dismissed.

Since the dismissal of the Sylvest suit, CIGNA has received statutory notice from the Attorney General's office that a formal complaint has been filed by a doctor charging that CIGNA violated the Any Willing Provider statute by rejecting his application to its provider panel. Moreover, CIGNA has received, and would like to reject, applications from a number of physicians seeking inclusion in its network of providers.

B. PROCEEDINGS

In an effort to free themselves from the threat of suit for the violation of the Any Willing Provider statute, CIGNA and CGLIC brought this action against Ieyoub in federal district court, seeking *inter alia* (l) a declaratory judgment holding that the Any Willing Provider statute is preempted by ERISA; and (2) an injunction prohibiting the commencement of any action against them for alleged violations of the Any Willing Provider statute. The district court granted summary judgment declaring that ERISA preempts the Any Willing Provider Statute insofar as it relates to third party administrators and health care plans that provide services to ERISA-qualified benefit plans, and issued an injunction barring Ieyoub from enforcing the statute against CIGNA and CGLIC. Ieyoub timely appealed.

II. ANALYSIS

A. STANDARD OF REVIEW

When reviewing a grant of summary judgment, we view the facts and inferences in the light most favorable to the non-moving party[15]; and we apply the same standards as those governing

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[15]*See Cavallini v. State Farm Mut. Auto Ins. Co.*, 44 F.3d 256, 266 (5th. Cir. 1995).

the trial court in its determination.[16] Summary judgment must be granted if a court determines "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."[17]

B. ERISA PREEMPTION[18]

1. Preemption Doctrine

The first question we must address is whether the Any Willing Provider statute is preempted pursuant to § 514(a) of ERISA. Section 514(a) states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" that is covered by the federal statute.[19] Courts have interpreted this preemption clause broadly, observing that its deliberatively expansive language was designed "to establish...plan regulation as exclusively a federal concern."[20]

The Supreme Court has given the phrase "relate to" a "broad common-sense meaning."[21] A state law relates to an ERISA plan "in the normal sense of the phrase if it has connection with or reference to such a plan."[22] A state law can relate to an ERISA plan even if that law was not specifically designed to

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[16]*See Neff v. Am. Dairy Queen Corp.*, 58 F.3d 1063, 1065 (5th. Cir. 1995), *cert. denied*, 116 S. Ct. 704 (1996).

[17]FED. R. CIV. P. 56(c).

[18]Ieyoub contends that we may not address the substantive issues of this case, as CIGNA and CGLIC lack standing and no active justiciable controversy exists. We agree with the district court's conclusion that these arguments are meritless, and we approve the reasoning set forth in the court's opinion. *See CIGNA Healthplan of Louisiana Inc. v. State of Louisiana. ex rel. Richard P. Ieyoub*, 883 F. Supp. 94 (M. D. La. 1995).

[19]*See* 29 U.S.C.S. § 1144(a).

[20]*Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138, 111 S. Ct. 478, 112 L. Ed. 2d 474 (1990) (internal quotations and citations omitted).

[21]*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987).

[22]*Shaw*, 463 U.S. at 96-97 (emphasis added).

affect such plans, and even if its effect is only indirect.[23] *If a state* law does not expressly concern employee benefit plans, it will still be preempted insofar as it applies to benefit plans in particular cases.[24] Of particular significance to our analysis today is the fact that the Supreme Court has repeatedly held that ERISA preempts "state laws that mandat[e] employee benefit structures or their administration."[25]

Nevertheless, ERISA preemption is not without limits. The Supreme Court has cautioned that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."[26] A unanimous Supreme Court has recently held in this regard that ERISA does not preempt state laws that have "only an *indirect economic effect* on the relative costs of various health insurance packages" available to ERISA-qualified plans.[27]

ERISA itself contains provisions which limit the scope of preemption.[28] For the purposes of the instant appeal, it is relevant that under § 514(b)(2)(A) of ERISA, preemption stops short of "any law of any State which regulates insurance."[29]

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[23]*See Rozzell v. Security Services. Inc.*, 38 F.3d 819, 821 (5th. Cir. 1994) (citing *Pilot Life*, 481 U.S. 41).

[24]*See Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enter. Inc.*, 793 F.2d 1456 (5th. Cir. 1986), *cert. denied*, 479 U.S. 1034, *and cert. denied*, 479 U.S. 1089 (1987).

[25]*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671, 1678, 131 L. Ed. 2d 695 (1995) [hereinafter *Travelers*] (citing *Shaw*, 463 U.S. 85; *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 112 L. Ed. 2d 356 (1990); *Alessi v. Raybestos-Manhattan, Inc.*, 451 US. 504, 101 S. Ct. 1895, 68 L. Ed. 2d 402 (1981)).

[26]*Shaw*, 403 U.S. at 100 n.21.

[27]*Travelers*, 115 S. Ct. at 1680 (discussing New York statute requiring hospitals to collect surcharges from patients covered by commercial insurers but not from patients insured by a Blue Cross/Blue Shield plan) (emphasis added).

[28]*See* 29 U.S.C.S. § 1144(b) (Law. Co-op 1990 & Supp. 1995).

[29]*See* 29 U.S.C.S. § 1144(b)(2)(A); *see also Travelers*, 115 5. Ct. at 1675.

2. Application of § 514(a) to the Instant Appeal

As discussed above, § 514(a) of ERISA provides for the preemption of state laws that either refer to or have a connection with an ERISA-qualified plan.[30] The Any Willing Provider statute qualifies for preemption on both counts. First, it refers to ERISA-qualified plans. More specifically, the statute requires that all licensed providers "who agre[e] to the terms and conditions of the preferred provider contract" must be accepted as providers in the PPO.[31] Under the terms of the Act, a preferred provider contract constitutes an agreement "between a provider or providers and *a group purchaser or purchasers* to provide for alternative rates of payment specified in advance for a defined period of time."[32] The Act specifically provides that group purchasers may include entities, such as "Taft-Hartley trusts or employers who establish or participate in self funded trusts or programs,"[33] which "contract [with health care providers] for the benefit of their . . . employees."[34] Given that these enumerated entities constitute ERISA-qualified plans,[35] the Act, and through it the Any Willing

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[30]*See e.q., Travelers*, 115 S. Ct. at 1677; *Dist. of Columbia v. Greater Washington Bd of Trade*, 506 U.S. 125, 113 5. Ct. 580, 121 L. Ed. 2d 513 (1992); Shaw, 463 U.S. at 96-97.

[31]*See* LA. Rev. STAT. ANN. § 40:2202(5)(C).

[32]*See* LA. REV. STAT. ANN. § 40:2202(5)(a) (emphasis added).

[33]*See* LA. REV. STAT. ANN. § 40:2202(3)(a).

[34]*See id.* ("'Group purchaser' may include:...Entities which contract for the benefit of their insured [sic], *employees*, or members such as insurers, self-funded organizations, *Taft- Hartley trusts*, or *employers who establish or participate in self funded trusts or programs*.") (emphasis added). We note that the statute would be considerably clearer if it had been drafted as follows: "'Group purchaser' may include:...Entities (such as self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs) which contract for the benefit of their insured [sic], employees, or members."

[35]*See* 29 U.S.C.S. § 1002(1)(A) (Law. Co-op 1992) (defining an employee welfare benefit plan as "any plan, fund, or program which...is...maintained by an employer...to the extent that such plan, fund, or program...is maintained for the purpose of providing for its participants...medical...care or benefits ..."); *see also* 29 U.S.C.S. § 1002(1)(B) (Law. Co-op 1992) (including in the definition of employee welfare benefit plans programs providing "any benefit described

Provider statute,[36] expressly refers to ERISA plans.

Moreover, the statute "relates to" ERISA plans in the sense that it is connected with such plans. The Supreme Court has emphasized that preemption is appropriate on this ground when statutes "mandat[e] employee benefit structures or their administration."[37] In the instant case, ERISA plans that choose to offer coverage by PPOs are limited by the statute to using PPOs of a certain structure—i.e., a structure that includes every willing, licensed provider. Stated another way, the statute prohibits those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider. As such, the statute connects with ERISA plans.

Neither is it of any consequence that plans might not choose to offer coverage by PPOs: It is sufficient for preemption purposes that the statute eliminates the choice of one method of structuring benefits.[38] The fact that neither CIGNA nor CGLIC is itself an ERISA plan is likewise inconsequential: By denying insurers, employers, and HMOs the right to structure their benefits in a particular manner, the statute is effectively requiring ERISA plans to purchase benefits of a particular structure when they

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in section 302(c) of the Labor Management Relations Act"). The referenced section of the Labor Management Relations Act provides for the establishment of Taft-Hartley trusts. *See* 29 U.S.C.S. § 186(c) (Law. Co-op 1993); *Lickteig v. Business Men's Assurance Co. of Am.*, 61 F.3d 579, 581 n.3 (8th Cir. 1995).

[36]We recognize that in holding that the statute refers to ERISA plans, we rely heavily on language that is found not in the text of the statute itself, but rather in the surrounding provisions of the Act that define the key terms of the statute. As these provisions are indispensable to the interpretation and application of the statute, we cannot separate the references to ERISA in those provisions from such references in the statute itself.

[37]*See Travelers*, 115 S. Ct. at 1678.

[38]*See, e.g., Alessi*, 451 at 524 (discussing a state statute that banned pension benefit offsets based on workers compensation awards, and holding that the statute related to ERISA plans pursuant to § 514(a) because it "eliminate[d] one method for calculating . . . benefits . . . that is permitted by federal law"); *see also FMC Corp.*, 498 U.S. at 60 (holding that statute related to ERISA plans pursuant to § 514(a) because it "prohibit[ed] plans from being structured in a manner requiring reimbursement in the event of a recovery from a third party").

contract with organizations like CIGNA and CGLIC.[39] In that regard, the statute "bears indirectly but substantially on all insured plans,"[40] and is accordingly preempted by ERISA.[41] Ieyoub and amici curiae[42] strenuously argue that this conclusion is barred by the Supreme Court's recent decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,[43] which was decided shortly after the district court issued its opinion in the instant case. In *Travelers*, the Court held that ERISA does not preempt a New York statute that requires hospitals to collect surcharges from patients covered by commercial insurers, but not from patients insured by Blue Cross & Blue Shield plans. The plaintiffs in *Travelers* argued that the New York statute was preempted by ERISA because it "make[s] the Blues more attractive (or less unattractive) as insurance alternatives and thus ha[s] an *indirect economic effect* on choices made by insurance buyers, including ERISA plans."[44] The Supreme Court disagreed, holding

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[39]*See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 5. Ct. 2380, 85 L. Ed. 2d 728 (1985) (holding that a statute "relates to" ERISA plans for the purposes of preemption if it "requires [the plans] to purchase the . . . benefits specified in the statute when they purchase a certain kind of common insurance policy.").

[40]*See Metropolitan Life*, 471 U.S. at 739.

[41]*Cf. Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir.) (holding that Virginia statute prohibiting insurance companies from unreasonably discriminating in establishing PPOs is covered by ERISA's preemption provision because it "restricts the ability of an insurance company to limit the choice of providers that otherwise would confine the participants of an employee benefit plan to those preferred by the insurer") (also holding that the statute was saved from preemption by ERISA's insurance savings clause), cert. *denied*, 114 5. Ct. 579 (1993); *Blue Cross and Blue Shield of Atlanta v. Nielsen*, No. CV-94-L-1265-S, 1996 U.S. Dist. LEXIS 1970 (Jan. 31, 1996) (holding that Alabama's equivalent of the Any Willing Provider statute is preempted by ERISA).

[42]A brief was filed in support of Ieyoub's position by the Louisiana State Medical Society and the Louisiana Dental Association acting as amici curiae.

[43]115 S. Ct. 1671.

[44]*See id.* at 1679 (emphasis added).

that statutes that have "only an indirect economic effect on the relative costs of various health insurance packages"[45] available to ERISA plans are not preempted by ERISA. The Court reasoned that "[a]n indirect economic influence...does not bind plan administrators to any particular choice."[46] The Court also emphasized the limited nature of its holding:

> [W]e do not hold today that ERISA preempts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage...and that such a state law might indeed be preempted under § 514. But as we have shown, New York's surcharges do not fall into [that] category; *they affect only indirectly the prices of insurance policies*, a result no different from myriad state laws in areas traditionally subject to local regulation...[47]

Unlike the New York statute at issue in *Travelers*, Louisiana's Any Willing Provider statute specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner. In other words, the Louisiana statute does not merely raise the cost of the implicated benefits; it delineates their very structure. As such, the statute falls outside the purview of the limited *Travelers* holding: The Court there repeatedly recognized that ERISA preempts "state laws that mandat[e] employee benefit structures."[48] Accordingly, we hold that the *Travelers* decision leaves undisturbed our conclusion that Louisiana's Any Willing Provider statute is preempted by ERISA.

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[45] *Id.* at 1680.

[46] *Id.*

[47] *Id.* at 1683 (emphasis added) (citations omitted).

[48] *Id.* at 1678; *see also id.* at 1679 (distinguishing New York law from preempted laws on ground that it "does not bind plan administrators to any particular choice"); *id.* at 1681.

3. The Insurance Exception

Determining that the Louisiana statute "relates to" ERISA plans and is therefore covered by ERISA's broad preemption provision does not complete our inquiry. We must next consider whether the statute is nonetheless saved from preemption by one of the exceptions embodied in ERISA's savings clause. This clause provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates *insurance*, banking, or securities."[49] In *Metropolitan Life Insurance Co. v. Massachusetts*,[50] the Supreme Court delineated the requirements that a statute must meet to come within the insurance facet of the savings clause. As we have noted in prior opinions, the Court took a conjunctive two-step approach:

> First, the court determined whether the statute in question fitted the common sense definition of insurance regulation. Second, it looked at three factors: (1) Whether the practice (the statute) has the effect of spreading the policyholders' risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. If the statute fitted the common sense definition of insurance regulation *and* the court answered "yes" to *each* of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption.[51]

Thus, if a statute fails either to fit the common sense definition of insurance regulation or to satisfy any one element of the three-factor *Metropolitan Life* test, then the statute is not exempt from preemption by the ERISA insurance savings clause.[52]

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[49]29 U.S.C.S. § 1144(b)(2)(A) (emphasis added).

[50]471 U.S. 724.

[51]*Tingle v. Pac. Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993) (citations omitted) (emphasis added); *See also NGS Am., Inc. v. Barnes*, 998 F.2d 296, 299 (5th Cir. 1993).

[52]*See Tingle*, 996 F.2d at 108; NGS Am., 998 F.2d at 299.

When we begin to apply that test to Louisiana's Any Willing Provider Statute, we may start and finish with the third factor of the *Metropolitan Life* test: On its face, Louisiana's statute obviously is not "limited to entities within the insurance industry." Even though the statute lists insurers as one group covered by its terms, it also specifies, in a non-exclusive list, that it applies to "self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs,"[53] as well as "health care financiers, third party administrators, providers, or other intermediaries."[54] As the statute fails to meet the third factor of the *Metropolitan Life* test,[55] we affirm the district court's holding that the statute is not saved from preemption by the insurance exception of § 514(b) of ERISA.

III. CONCLUSION

For the foregoing reasons, we affirm the district court's grant of summary judgment declaring that ERISA preempts the Any Willing Provider Statute insofar as it relates to third party administrators and health care plans that provide services to ERISA-qualified benefit plans. We also affirm the court's grant of an injunction barring Ieyoub from enforcing the statute against CIGNA and CGLIC.

AFFIRMED.

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[53]LA. REV. STAT. ANN. 40:2202(3)(a).

[54]LA. REV. STAT. ANN. 40:2202(3)(b).

[55]*See Iron Workers Mid-South Pension Fund v. Terotechnology Corp.*, 891 F.2d 548 (5th Cir.), *cert. denied*, 497 U.S. 1924 (1990). As discussed above, having determined that the statute fails to meet one element of the *Metropolitan Life* test, we need not consider whether the statute meets the other elements.

APPENDIX C

[Filed May 4, 1995]

United States District Court
Middle District of Louisiana

No. 94-885

CIGNA HEALTHPLAN OF LOUISIANA, INC.
CONNECTICUT GENERAL LIFE INSURANCE COMPANY,
Plaintiffs

v.

STATE OF LOUISIANA, EX REL. RICHARD P. IEYOUB,
ATTORNEY GENERAL,
Defendant

JUDGMENT AND ORDER OF INJUNCTION

For the reasons stated in this Court's Order and Reasons entered on April 17, 1995, this Court hereby enters the following final judgment and order of injunction.

It is hereby **ORDERED, ADJUDGED AND DECREED** that:

1. Judgment is entered in favor of the plaintiffs and against the defendant on Count I of plaintiffs' complaint at defendant's cost.

2. Judgment is entered dismissing Count II of plaintiff's complaint.

3. Louisiana Revised Statues 40:2202(5)(c), as applied to health care service plans serving participants and beneficiaries of ERISA-regulated employee welfare benefit plans, is declared pre-empted by ERISA and thus violative of the Supremacy Clause of the U.S. Constitution, Art. VI, cl 2.

4. Richard P. Ieyoub, in his official capacity as the Attorney General of Louisiana, and his officers, agents, servants, employees, attorneys, or any of them, and all persons acting in concert or participation with the defendant, are permanently enjoined:

(a) from bringing suit against plaintiffs for alleged violations of Louisiana Revised Statutes 40:2202(5)(c);

(b) from issuing additional "Notice of R.S. 51:1401 Complaint" letters to plaintiffs, following complaints to the Attorney General from health care providers whose applications to become members of plaintiffs preferred provider networks are rejected based on criteria other than the providers' ability and willingness to meet the terms and conditions of these networks;

(c) from applying advisory opinion No. 92-824, as issued on February 8, 1993, to plaintiffs.

New Orleans, Louisiana, this 27th day of April, 1995.

s/ Martin L.C. Feldman
United States District Judge

APPENDIX D

[Filed April 17, 1995]

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF LOUISIANA

No. 94-885

CIGNA HEALTHPLAN OF LOUISIANA, INC.
CONNECTCUT GENERAL LIFE INSURANCE COMPANY
Plaintiffs

versus

STATE OF LOUISIANA, EX REL. RICHARD P. IEYOUB,
ATTORNEY GENERAL
Defendant

ORDER AND REASONS

Two contradictory motions are before the Court: defendant's motion to dismiss and plaintiffs' motion for partial summary judgment. They explore some new issues of law. For the reasons that follow, defendant's motion is GRANTED in part and DENIED in part and plaintiffs' motion is GRANTED.

Background

Plaintiffs, CIGNA Healthplan of Louisiana, Inc. ("CIGNA") and Connecticut General Life Insurance Company ("CGLIC"), have sued Richard P. Ieyoub, in his official capacity as the Attorney General of the State of Louisiana, for a declaratory judgment concerning § 40:2202(5)(c) of the Louisiana Revised Statutes, the "Any Willing Provider Statute." In Count I, plaintiffs seek a declaratory judgment that, at least as applied to health care service plans that serve participants and beneficiaries of employee welfare benefit plans regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"), the Any Willing Provider Statute is preempted by ERISA and thus violates the Supremacy Clause of the United States Constitution, art. VI, cl. 2. As an alternative claim, in Count II plaintiffs seek a declaratory judgment that the statute

violates the Due Process Clause of the Fourteenth Amendment of the Constitution because it interferes with the plaintiffs' freedom to contract with health care providers of their choice. Plaintiffs also seek an order enjoining the State from suing the plaintiffs for violations of the statute and from providing the statutory notification that would enable private parties to obtain treble damages in a civil suit brought under Louisiana Revised Statutes § 51:1409(A), the Unfair Trade Practices and Consumer Protection Law.

CIGNA and CGLIC offer a variety of health care coverages and administrative services to health care consumers through their managed care programs. Under the Any Willing Provider Statute, they are "group purchasers" who serve as brokers and third party administrators of such programs. CIGNA is a licensed HMO and provides prepaid health care coverage to its enrolled subscribers through a network of selectively contracted health care providers, such as physicians and hospitals. CIGNA markets its predetermined cost provider panel to health care consumers, either directly or through employers, insurance companies, or other groups, who are given economic incentives to patronize its network of preferred providers.

By contract, CGLIC markets the CIGNA network to consumers in Louisiana. CGLIC, a duly licensed health insurer, offers and administers both insured and self-funded health benefit plans to its clients, including sponsors of ERISA-regulated employee welfare benefit plans. CGLIC encourages the participants and beneficiaries of its health benefit plans to utilize the services of the CIGNA network through such incentives as coinsurance differentials. These insured and self-funded plans are "preferred provider organizations" ("PPO"s) within the meaning of Louisiana Revised Statute § 40:2202(5)(a). Among the subscribers to CIGNA's and CGLIC's programs are employee benefit plans with HMO or PPO options.

CIGNA and CGLIC compete with many other managed care firms to contract with hospitals and doctors throughout Louisiana for the delivery of health care services to its participants and beneficiaries. Those who participate in the preferred provider network are able to reduce their fees for services

because the limited size of the network insures each provider a sufficient volume of patients to warrant the fee reductions. The preferred provider network also reduces costs and is said to improve services by fostering competition between providers. According to plaintiffs, this selective contracting is what enables them, as well as the employee benefit plans they serve, to control or reduce costs and assure quality.

The plaintiffs claim that their ability to continue to offer services through high quality and low cost HMOs and PPOs in Louisiana is threatened by the Any Willing Provider Statute. In 1984 the statute became effective; it authorizes the formation of preferred provider organizations to assist in reducing health care costs in Louisiana. § 40:2201(C). The statute states: "No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health care services within the limits of his license." § 40:220(5)(c). The plaintiffs maintain that the statute requires them, and as such, employee benefit plans that use their network, to add any health care provider who is willing and able to meet the terms and conditions of their provider contracts.

In February 1993 the Louisiana Attorney General issued Advisory Opinion Number 92-824, which stated his opinion that the violation of the Any Willing Provider Statute would be considered an unlawful trade practice giving rise to a private cause of action under the Unfair Trade Practices and Consumer Protection Law, La. Rev. Stat. Ann. § 51:1405(A) (West 1987). Subsequently, in January 1994, Dr. Ronald D. Sylvest, a health care provider on CIGNA's preferred provider panel, was notified that his services were no longer needed and that (pursuant to a termination clause) his contract with CIGNA would be terminated, effective early March 1994. Dr. Sylvest sued CIGNA, alleging that CIGNA violated the Any Willing Provider Statute by terminating his participation on the panel. A temporary restraining order was issued against CIGNA, but the suit was subsequently dismissed after a settlement was reached. CIGNA notes that at the point of settlement, it had already incurred substantial legal expenses in its defense.

In May and July 1994, Drs. Neil Smith and John Saer submitted applications for admission to CIGNA's preferred provider panel. Because CIGNA had already contracted to place a number of other doctors of Dr. Smith's and Dr. Saer's specialties on its panel, CIGNA rejected their applications. CIGNA is currently processing more applications from other doctors in Louisiana for admission to its panel. CIGNA wishes to exclude some of these applicants because enough doctors in the relevant specialties have already been signed up.

Also, in May 1994 the Attorney General mailed a "Notice of R.S. 51:1401 Complaint" to plaintiffs. The statutory notice informed them that a formal complaint had been filed with the Attorney General's office by another doctor, Dr. Stephen Anthony Scalco, charging that the plaintiffs had violated the Unfair Trade Practices and Consumer Protection Law by rejecting his panel application in violation of the Any Willing Provider Statute. The notice further warned that if the rejection was found to violate the statute and constitute an unfair trade practice under the Unfair Trade Practices and Consumer Protection Law, Dr. Scalco would be entitled to treble damages.

To engage their request for declaratory relief, plaintiffs allege that this series of events makes them vulnerable to additional or immediate suit for violation of the Any Willing Provider Statute. They note that such suits will force them to incur still more costly legal expenses as well as cause harm to their reputation among consumers. Because the Unfair Trade Practices and Consumer Protection Law may also be enforced by the Attorney General under La. Rev. Stat. Ann. § 51:1407 (West 1987), plaintiffs claim to bear a substantial risk of suit by the Attorney General to enforce the provisions of the Any Willing Provider Statute.

The State has moved for dismissal of both counts of plaintiffs' complaint, asserting a number of defenses in bar. Plaintiffs have responded with a motion for partial summary judgment as to Count I of their complaint, seeking injunctive relief and a declaratory judgment that the Any Willing Provider Statute is preempted by ERISA on the ground that the statute represents the improper extension of state law into an area exclusively reg-

ulated by ERISA.[1] The Louisiana State Medical Society and the Louisiana Dental Association have filed amici curiae papers in support of the State's position.

I. Motion to Dismiss

The Court will consider each of the State's grounds for dismissal in turn.[2]

A. Subject Matter Jurisdiction

1. Federal Question Jurisdiction

a. ERISA Preemption Claim

The State contends that this Court has no subject matter jurisdiction over plaintiffs' ERISA preemption claim because plaintiffs are not enumerated parties entitled to bring a civil enforcement action under ERISA. *See* 29 U.S.C. § 1132(a). The plaintiffs respond that the Court has federal question jurisdiction under 28 U.S.C. § 1331 because they claim that the Any Willing Provider Statute violates the Supremacy Clause of the United States Constitution by virtue of ERISA's broad preemption sweep. *See* 29 U.S.C. § 1144. The Court must determine whether § 1331 provides plaintiffs their ticket to a seat in federal court. The Court concludes that it does.

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[1]Plaintiffs urge that the Any Willing Provider Statute "affects employee benefit plans utilizing HMO and PPO coverages by altering their administration, eroding the quality of health care services which they provide[,] and increasing the costs of such plans for employers and their employees in Louisiana."

[2]Because the State's defenses under the Eleventh Amendment and the Anti-Injunction Act are patently without merit, the Court only summarily addresses them here. First, the State claims that it is immune from suit under the Eleventh Amendment. Clearly, the State is not entitled to such a defense under these circumstances.

See Ex Parte Young, 28 S.Ct. 441 (1908); *Edelman v. Jordan*, 94 S.Ct. 1347 (1974). *See also Jones v. Louisiana ex rel. Bd. of Trustees*, 764 F.2d 1183, 1185-86 (5th Cir. 1985) (although state official not named in caption, named in body of complaint and thus Eleventh Amendment defense meritless). Secondly, the State maintains that the Anti-Injunction Act effectively bars plaintiffs' suit. However, plaintiffs plainly do not seek to stay any current or pending state court proceedings. *See Dombrowski v. Pfister*, 85 S.Ct. 1116 (1965); *B & A Pipeline Co. v. Dorney*, 904 F.2d 996 (5th Cir. 1990). Thus, both defenses are without merit.

In *Shaw v. Delta Air Lines. Inc.*, 103 S.Ct. 2890 (1983), plaintiffs, employers and a plan sponsor, claimed that a state law was preempted by ERISA. The Supreme Court held that the federal court indeed had subject matter jurisdiction over plaintiffs' suit and noted that

> [i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. A plaintiff who seeks injunctive relief from state regulation on the ground that such regulation is preempted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.

Id. at 2899 n.14 (citations omitted). Although the State invokes the Supreme Court's decision in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 103 S.Ct. 2841 (1983) in support of its argument that the plaintiffs' assertion of ERISA preemption does not give rise to federal jurisdiction[3], the Supreme Court explicitly held in *Shaw* that *Franchise Tax Board* did not call into question the federal court's jurisdiction to decide cases seek-

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[3]The State also attempts to use two Louisiana federal district court decisions. Both are equally inapplicable because they involved attempts by defendants to remove to federal court on the *defense* of ERISA preemption and neither involved a suit for declaratory or injunctive relief against the State. In *Gavin North Sherwood Chiropractic Clinic, A.P.C. v. Brouer*, 838 F. Supp. 274 (M.D. La. 1993), an association of chiropractic clinics brought suit in Louisiana state court against a preferred provider organization to be admitted as preferred providers. *Id.* at 275. The plaintiffs alleged a violation of the Any Willing Provider Statute. When the defendants attempted to remove to federal court claiming ERISA preemption, the Court ordered the case remanded to state court for lack of subject matter jurisdiction. *Id.* at 276. In *Willis-Knighton Medical Center v. Community Health Network of Louisiana. Inc.*, Civ. A. No. 93-1503, slip op. at 3 (W.D. La. Dec. 16, 1993), plaintiffs, a hospital and numerous physicians, sued an HMO in Louisiana state court for breach of contract. The plaintiffs expressly did not allege a violation of the Any Willing Provider Statute and in fact no mention of the statute is made in the opinion. *Id.* at 9-10. When the defendant attempted to remove to federal court claiming that plaintiffs' breach of contract claim was preempted by ERISA, the Sherman Act and the Clayton Act, the Court ordered the case remanded to state court for lack of subject matter jurisdiction.

ing injunctive and declaratory relief on ERISA preemption grounds. *Shaw*, 103 S.Ct. at 2899 n.14.

Moreover, a recent Fifth Circuit decision expressly supports the plaintiffs' position that this Court can properly exercise its subject matter jurisdiction. In *Self-Insurance Institute of America. Inc. v. Korioth*, 993 F.2d 479 (5th Cir. 1993), the court held that subject matter jurisdiction exists under § 1331 when a party seeks both declaratory and injunctive relief based upon the contention that a state law violates the Supremacy Clause by virtue of ERISA preemption, even when the plaintiffs are nonenumerated ERISA parties who could not sue under ERISA's civil enforcement provision. *Id.* The court commented that "a federal declaratory judgment action affirmatively brought to determine whether a state law is preempted presents a valid basis for federal question jurisdiction." *Id.* at 483; *see also Hydrostorage. Inc. v. Northern Cal. Boilermakers Local Joint Apprenticeship Comm.*, 891 F.2d 719, 725 (9th Cir. 1989), *cert. denied*, 111 S.Ct. 72 (1990) (court had subject matter jurisdiction under § 1331 over suit for declaratory and injunctive relief brought-by a non-enumerated party to prevent enforcement of a state regulation claimed to be preempted by ERISA). As in *Korioth*, the fact that there is no underlying state court suit involved here makes "the preemption issue . . . particularly amenable to a federal forum." *Id.* at 482. And as did the defendants in *Korioth*, both the State and *amici curaie* here confuse the issue of standing with that of jurisdiction. *See id.* at 483-84.

The State also maintains that plaintiffs' ERISA preemption claim is insubstantial as obviously without merit; it claims that prior decisions foreclose controversy on the subject. *See New Orleans Public Serv.. Inc. v. City of New Orleans*, 782 F.2d 1236, 1241, *withdrawn in part on other grounds*, 798 F.2d 858 (5th Cir. 1986), *cert. denied*, 107 S.Ct. 1910 (1987). In determining the substantiality of plaintiffs' ERISA claim, the Court must keep in mind the rigorous test for dismissal. And the Court may not dismiss "if there is 'any foundation of plausibility to the claim." *Id.* (quoting *Meason v. Bank of Miami*, 652 F.2d 542, 547 (5th Cir. 1981), *cert. denied*, 102 S.Ct. 1428 (1982)). The Court need not conclude that the plaintiffs will ultimately prevail on their claim. *NOPSI*, 782 F.2d at 1242. As this preempting question is a matter of first impression, the Court

cannot conclude that plaintiffs' claims are clearly without merit or foreclosed by precedent.

b. Due Process Claim

In Count II of their complaint, plaintiffs assert a Fourteenth Amendment due process claim. The Due Process Clause provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1. Plaintiffs have pleaded they should have the "liberty...to contract with providers of their choice to establish and maintain an economically viable preferred provider arrangement pursuant to [the Any Willing Provider Statute]." (Pls.' Compl. 34). They maintain that, on the contrary, such liberty is impeded by the Any Willing Provider Statute. Because the plaintiffs expressly set forth a claim under the Constitution, their claim necessarily arises under federal law for purposes of § 1331. *See, e.g., Powell v. McCormack*, 89 S.Ct. 1944, 1960-61 (1969).

1. Failure to State a Claim

The State's argument concerning plaintiffs' due process claim turns more on the viability of their claim than the Court's power to adjudicate it. Because the State essentially attacks plaintiffs' claim on the merits, the Court will consider whether under Federal Rule of Civil Procedure 12(b)(6), plaintiffs' due process claim states a claim upon which relief may be granted. The Court finds that it does not and thus dismisses Count II of plaintiffs' complaint.

In support of due process relief, plaintiffs argue that the Any Willing Provider Statute is not rationally related to a legitimate state purpose. *See, e.g., Pension Benefit Guar. Corp. v. R.A. Gray & Co.*, 104 S.Ct. 2709 (1984). Rather, they say, the statute forces PPOs to contract with each qualified provider who is willing to participate, thus spreading a limited pool of patients over an unlimited provider pool. They also argue that the net result of compliance with the statute is increased costs for both PPOs and HMOs as well as patients, a result that is in direct contravention with the statute's articulated purpose of providing an "incentive for purchasers and providers to strive for more cost-efficient and effective methods of providing quality patient care and more efficient

payment for services rendered." La. Rev. Stat. Ann. § 40:2201(B) (West 1987). However, even assuming that plaintiffs have a liberty or property interest that deserves protection, an issue the Court does not reach, the Court concludes that the statute is rationally related to the legitimate and asserted State purpose of assuring patient access to quality health care without restricting the freedom to choose one's provider.

2. Case or Controversy[4]

Under both the Declaratory Judgment Act, 28 U.S.C. § 2201 and Article III of the Constitution, the Court may adjudicate a claim for declaratory relief only when an actual controversy exists. *Maryland Casualty Co. v. Pacific Coal & Oil Co.*, 61 S.Ct. 510, 511 (1941). The State denies the existence of a live controversy as to both counts of plaintiffs' complaint and asserts that plaintiffs' claims are based upon mere conjecture as to whether the State will ever file suit against the plaintiffs for a violation of the Any Willing Provider Statute. It also urges that any declaratory judgment would be advisory in nature.

Plaintiffs counter that not only have they been sued by at least one person for violating the statute, but also that the threat of future suits by the State and other persons is beyond mere speculation. Plaintiffs remind us that although the Attorney General has not yet sued them to enforce the statute, he has issued a formal opinion in which he concluded that the statute provides for a private right of action under the Unfair Trade Practices and Consumer Protection Law, *see First Gibraltar Bank. FSB v. Morales*, 19 F.3d 1032, 1038 (5th Cir.), *cert. denied*, 115 S.Ct. 204 (1994), *vacated and superseded on other grounds*, 42 F.3d 895 (5th Cir. 1995), which also accords to the State an enforcement mechanism of its own. La. Rev. Stat. Ann. § 51:1407 (West 1987). The

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[4]Although the State catalogs this issue separately, because the analysis is the same under either theory, the Court will consider concurrently whether an actual case or controversy exists under both the Declaratory Judgment Act and the United States Constitution. *See Texas v. West Publishing Co.*, 882 F.2d 171, 175 (5th Cir. 1989), *cert. denied*, 110 S.Ct. 869 (1990) ("case or controversy requirement of Article II of the . . . Constitution is identical to the actual controversy requirement under the Declaratory Judgment Act".)

Attorney General has also given plaintiffs the statutory notice of a complaint which asserts a claim based upon plaintiffs' violation of the Any Willing Provider Statute because of their denial of a doctor's right to become a network provider. *See* La. Rev. Stat. Ann. § 51:1409(A) (West 1987).

The Court finds that an actual justiciable controversy of sufficient immediacy and reality persists which vests the Court with the discretion to entertain a request for declaratory relief. *See Texas v. West Publishing Co.*, 882 F.2d 171, 175 (5th Cir. 1989), *cert. denied*, 110 S.Ct. 869 (1990). The preemption question presented implicates an issue of law and thus is aptly fit for judicial determination. *First Gibraltar*, 19 F.3d at 1038. Moreover, the plaintiffs ought not be "'placed in the dilemma of incurring the disadvantages of complying [with the statute] or risking penalties for noncompliance.'" *Id.* at 1039 (quoting *Whitney v. Heckler*, 780 F.2d 963, 969 n.6 (11th Cir.), *cert. denied*, 107 S. Ct. 65 (1986)); *see also Babbitt v. United Farm Workers Nat'l Union*, 99 S.Ct. 2301, 2308 (1979).[5]

3. Standing to Bring ERISA Preemption Claim

The substance of the State's standing argument is that plaintiffs' injuries arise from the state statute's requirements, and not from any right inherent in ERISA itself[6], thus depriving plaintiffs of standing. This argument, however, fails to take into account the fact that plaintiffs bring their suit under the Supremacy Clause and the Due Process Clause of the Fourteenth Amendment.

Two recent decisions of the Fifth Circuit undermine the State's argument. First, as discussed earlier, in *Self-Insurance*

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[5]The Court notes that the plaintiffs' risk of suit and the potential incurrence of significant economic losses to both plaintiffs and their subscribers as a result of their compliance with the statute creates a real controversy. If forced to comply with the statute, plaintiffs would suffer significant economic cost as a result of the restructuring of their plan to accommodate all willing providers.

[6]Neither party debates that plaintiffs have no mechanism with which to bring a suit under the civil enforcement action provisions of ERISA. *See* 29 U.S.C. § 1132(a). The case literature, as reflected in *Korioth*, separates the subject matter jurisdiction analysis and the standing analysis. Both, however, implicate related doctrine.

Institute of America. Inc. v. Korioth, 993 F.2d 479 (5th Cir. 1993), the court held that an organization composed of employer sponsors, plan sponsors, and *third party administrators*[7], although not enumerated in ERISA's civil enforcement provision, had standing to bring suit seeking a declaratory judgment and related injunctive relief that a Texas statute was preempted by ERISA. Id. at 484-85. Relying on *Association of Data Processing Services Organizations. Inc. v. Camp*, 90 S.Ct. 827 (1970), the Fifth Circuit concluded (1) that plaintiffs would suffer injury in fact — economic injury — through the statute's enforcement and that such injury would likely be remedied by the court's finding that the statute was preempted by ERISA, and (2) that third-party administrators providing services to ERISA plans fall within ERISA's zone of interest, even if unenumerated therein.[8] *Korioth*, 993 F.2d at 484; *see also* 29 U.S.C. § 1002(14)(A)-(B) (ERISA defines a "party in interest" as a person providing services to employee benefit plans. Here, plaintiffs indisputably provide services to such plans through their HMOs and PPOs). In *NGS American. Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993) ("NGSII"), *aff'g* 805 F. Supp. 462 (W.D. Tex. 1992) ("NGSI"), the court again agreed that a third party administrator of an ERISA plan had standing to seek a declaration against the state that a state statute was preempted by ERISA. *NGSII*, 998 F . 2d at 298 n.2; *see also NGSI*, 805 F. Supp. at 465 (holding that " [e]ven if [a] third-party administrator is not a 'fiduciary' under ERISA, such an administrator still has standing...pursuant to...§ 1331").

In *Lujan v. Defenders of Wildlife*, 112 S.Ct. 2130 (1992), the Supreme Court spoke of three prerequisites of standing:

> First, the plaintiff must have suffered an 'injury in fact' - an invasion of a legally-protected interest which is (a) con-

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[7]The State acknowledges that these plaintiffs are third party administrators and service providers to health benefit plans falling within the scope of ERISA. (*See, e.g.*, Defs.' Mot. to Dismiss at 2-3; Rebuttal Mem. at 6, 8).

[8]The court noted that its finding that third-party administrators fall within the zone of interest was buttressed by the fact that state law defined such administrators as fiduciaries. However, the court did not find this fact decisive to its determination. *See Korioth*, 993 F.2d at 484.

> crete and particularized, and (b) 'actual or imminent, not 'conjectural' or 'hypothetical.'
>
> Second, there must be a causal connection between the injury and the conduct complained of — the injury has to be 'fairly...trace[able] to the challenged action of the defendant, and not...th[e] result [of] the independent action of some third party not before the court.'
>
> Third, it must be 'likely,' as opposed to merely 'speculative,' that the injury will be 'redressed by a favorable decision.'

Id. at 2136 (citations omitted). The burden is on the plaintiffs to establish the existence of these three elements. *Id.*

Plaintiffs meet their burden. Plaintiffs have established sufficient injury.[9] Moreover, there is a connection between the injury and the statute challenged, the Any Willing Provider Statute.[10] Finally, it is likely that, at least to the extent that their programs are aimed at employee benefit plans, the plaintiffs' injury could be redressed by a determination that the Any Willing Provider Statute is preempted by ERISA.

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[9]As in *Korioth*, the plaintiffs here, as discussed above, suffer the injury of economic loss. Contrary to the State's assertion, economic harm has long been considered sufficient palpable injury to give rise to standing. *E.g., O'Hair v. White*, 675 F.2d 680, 687 (5th Cir. 1982). This Court also emphasizes that

> "[w]hen the suit is one challenging the legality of government action or inaction, the nature and extent of facts that must be averred . . . in order to establish standing depends . . . upon whether the plaintiff is himself an object of the action . . . at issue. If he is, there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it."

Lujan, 112 S.Ct. at 2137.

[10]The State mischaracterizes the inquiry by implying that the statute challenged by the plaintiffs is not the Any Willing Provider Statute, but ERISA.

II. ERISA Preemption

A. Standard for Summary Judgment[11]

Federal Rule of Civil Procedure 56 instructs that summary judgment is proper if the record discloses no genuine issue as to any material fact such that the moving party is entitled to judgment as a matter of law. No genuine issue of fact exists if the record taken as a whole could not lead a rational trier of fact to find for the non-moving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 106 S.Ct. 1348 (1986).

B. Application

The Court now turns to the heart of the parties' dispute: whether the statute, as it applies to the employee benefit plans that use the plaintiffs' network of providers, is preempted by ERISA?

1. Relationship of the statute to ERISA

ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title." 29 U.S.C. § 1144(a). The Supreme Court has held that the preemption clause "establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' employee benefit plan governed by ERISA." *FMC Corp. v. Holliday*, 111 S.Ct. 403, 407 (1990). The preemption text is notably loose. A state law relates to an employee benefit plan and is thus preempted "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines. Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983). A state law may relate to an employee benefit plan and be preempted "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478, 483

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[11]The Court recognizes that the State challenged the preemption issue in their motion to dismiss under Federal Rule of Civil Procedure 12(b)(6). However, because the plaintiffs have filed a motion for partial summary judgment on this issue and neither party places any facts in dispute, thus not impacting the allegations of plaintiffs' complaint, the motions present a pure question of law, the resolution of which would be the same under either procedural vehicle.

(1990). However, although the preemptive scope of ERISA is deliberately expansive, it has its limits. The Supreme Court has cautioned that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n. 21, 103 S.Ct. at 2901 n.21. In applying these principles, the Court bears in mind that the determination of whether ERISA preempts a state law claim turns very much on congressional intent. *See Ingersoll-Rand*, 111 S.Ct. at 482.

Plaintiffs maintain that the Any Willing Provider Statute encounters and confronts ERISA plans for two reasons. They point out that the express terms of the statute seem to cover employee benefit plans. *See FMC Corp.*, 111 S.Ct. at 408 (statute's reference to "[a]ny program, group contract or other arrangement for payment of benefits" was sufficient to establish its relationship to ERISA plans). They also submit that the statute affects the structure and administration of ERISA plans, and therefore necessarily relates to such plans for preemption purposes.[12]

The Court agrees that the statute relates to employee benefit plans. The statute falls within the scope of Louisiana's Health Care Cost Control Act, La. Rev. Stat. Ann. §§ 40:2201-2205 (West 1987 & Supp. 1994), which directs its purpose at reducing health care costs. The language of the Act betrays the State's perception that the statute is no more than a law of general applicability, with no specific reference to ERISA-governed plans. On the contrary, several provisions point to the Act's express reference and applicability to employee benefit plans. The Act defines group purchasers as "[e]ntities which contract for the benefit of their insured, employees, or members such as insurers, self-funded organizations, . . . or employers who establish or participate in self funded trusts or programs [as well as e]ntities which serve as brokers for the formation of such contracts . " La. Rev. Stat. Ann.

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[12]"A state...law may be preempted even though it has no...direct nexus with ERISA plans if its *effect* is to dictate or restrict the choices of ERISA plans with regards to their benefits, structure, reporting and administration." *United Wire, Metal and Mach. Health and Welfare Fund v. Morristown Mem. Hosp.*, 995 F.2d 1179, 1193 (3d Cir.), *cert. denied*, 114 S.Ct. 382 (1993) (emphasis added).

§ 40 :2202 (3) (a) - (b) . The State does not dispute that this definition fits the plaintiffs. In defining the organization of PPOs, the Act expressly recognizes the interests of insureds and employees with its observation that "[t]he contractual...agreements [between the providers and group purchasers, such as plaintiffs here,] may also include incentives which encourage the insured employee or member to utilize the participating providers." La. Rev. Stat. Ann. § 40:2202(5) (b). Finally, the Act explicitly addresses the benefits due participants in plans that incorporate PPO options. *See* La . Rev. Stat . Ann . § 40: 2203 (C) . The statute may well have the effect of expanding the realm of choice of providers while increasing their potential costs, as well as the costs to their employer or plan sponsor. However, potentially increased cost is not the only result of the statute. The Court agrees with the plaintiffs that application of the statute impacts the employers' or plan sponsors' discretion as to how health benefits may be structured under their employee benefit plans. It explicitly directs that they may not structure their programs so as to exclude any provider willing and able to participate. *See Metropolitan Life Ins. Co. v. Massachusetts*, 105 S.Ct. 2380, 2388-89 (1985) (state statute requiring all insured benefit plans to purchase specific benefits when purchasing insurance 'relates to' employee benefit plans); *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir.), *cert. denied*, 114 S.Ct. 579 (1993) (Virginia's 'any willing provider statute' 'relates to' employee benefit plans); *cf. United Wire*, 995 F.2d at 1193 (holding that a statute regulating only hospital rates did not relate to ERISA plans merely because it had the net result of increasing insurers' and self-funded plans' costs of providing benefits).

Having determined that the Any Willing Provider Statute relates to an ERISA plan for purposes of preemption, the Court must next consider whether the statute is nonetheless saved from preemption as a law regulating insurance. *See* 29 U.S.C. § 1144(b)(2)(A).

2. Savings Clause

ERISA's savings clause deals with insurance regulation; it provides that "nothing in this subchapter shall be construed to

exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). It has the effect of "saving" state laws governing the business of insurance from ERISA preemption. *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. 1549, 1552 (1987).

The Fifth Circuit applies a multi-factor test to determine whether a state law falls under the savings clause:

> First, the court determine[s] whether the statute in question fit[s] the common sense definition of insurance regulation. Second, it look[s] at [the] three [McCarran-Ferguson] factors: (l) whether the practice (the statute) has the effect of spreading the policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.

Tingle v. Pacific Mut. Ins. Co., 996 F.2d 105, 107 (5th Cir. 1993). This Court must first inquire whether the Any Willing Provider Statute meets the common sense definition of insurance regulation.

> A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.

Pilot Life, 107 S.Ct. at 1554. *See also Hayden v. Blue Cross and Blue Shield of Alabama*, 843 F. Supp. 1427, 1434 (M.D. Ala. 1994) (a statute affecting not only the insurance industry, but also other non-insured health care plans and agreements failed the common sense test).

The Court finds that the Any Willing Provider Statute fails the common sense test because it is not specifically directed towards the insurance industry, but, rather, it expressly applies to entities outside the insurance industry, such as employers and Taft-Hartley trusts. *See* La. Rev. Stat. Ann. § 40:2202(3)(a)-(b) (West 1987); *Hayden*, 843 F. Supp. at 1434 ("[a]lthough [the statute at issue there] may have a substantial effect on the insurance industry, the law affects other health care plans and agreements

even though they are not a part of an insurance contract"); *cf. Stuart Circle*, 995 F.2d at 504 (holding that Virginia's statute was expressly limited to entities within the insurance industry).

Because Louisiana's Any Willing Provider Statute fails to meet the common-sense definition of insurance and at least one of the three McCarran-Ferguson factors,[13] the Court finds that the statute does not fall within ERISA's savings clause and is thus preempted to the extent that it relates to employee welfare benefit plans governed by ERISA. *See Tingle*, 996 F.2d at 108.

Accordingly, the defendant's motion to dismiss is DENIED in part and GRANTED in part, and plaintiffs' motion for partial summary judgment is GRANTED.

Plaintiffs are granted summary judgment as to Count I of their complaint. Count II of plaintiffs' complaint is DISMISSED. A Judgment and Order of Injunction that comports with this decision shall be submitted by plaintiffs for execution.

New Orleans, Louisiana, April 11, 1995.

s/ MARTIN L. C. FELDMAN
UNITED STATES DISTRICT JUDGE

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[13]It does not satisfy the third factor because, as previously noted, it is not limited to entities within the insurance industry.

APPENDIX E

CHAPTER 12. HEALTH CARE COST CONTROL

PART I. PREFERRED PROVIDER ORGANIZATIONS

Section

2201. Legislative considerations.
2202. Definitions.
2203. Authorization for Preferred Provider Organizations.
2204. Hospital participation- tangible benefit presumed.
2205. Utilization reviews; relief from liability and discovery; standards compliance.
2206 to 2216. Repealed.

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Acts 1979, No. 449, § 5, effective January 1, 1980, repealed former Chapter 12, which consisted of R.S. 40:2201 to 40:2216 as added by Acts 1964, No. 259, § 1 et seq., pertaining to air pollution control. Act 449, in § 1, also enacted the Louisiana Environmental Affairs Act (R.S. 30:1051 et seq., redesignated as R.S. 30:2001 et seq. and renamed the Louisiana Environmental Quality Act), Part III of which (R.S. 30:1081 et seq., redesignated as R.S. 30:2051 et seq.), the Louisiana Air Control Law, relates to the subject matter of this repealed Chapter. Prior to the repeal, Acts 1978, No. 615, § I had amended R.S. 40:2202 and 40:2204, Acts 1978, No. 786, § 5 had amended R.S. 40:2203 and 40:2204, Acts 1978 No. 383, § I had amended R.S. 40:2204, and Acts 1978, No. 383, § 2 had amended R.S. 40:2212.

PART I. PREFERRED PROVIDER ORGANIZATIONS

§ 2201. Legislative considerations

A. The legislature recognizes that health care costs have risen greatly over the past decade and must be contained without jeopardizing:

(1) The quality of care received by patients.

(2) The ability of health care providers to maintain, update, and expand their facilities to serve their patients and communities and to meet federal and state standards and regulations.

B. The legislature further recognizes that there must be some incentive for purchasers and providers to strive for more cost-efficient and effective methods of providing quality patient care and more efficient payment for services rendered.

C. Therefore, the state can assist in reducing health care costs by authorizing the formation of preferred provider organizations.

D. The legislature further recognizes that the state and governmental bodies can reduce the cost of providing health care benefits for their employees by contracting with a preferred provider organization.

Added by Acts 1984, No. 374, § 1, eff. July 6, 1984.

Historical and Statutory Notes

A prior R.S. 40:2201, part of the former Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § 5. See italic note preceding R.S. 40:2201.

The subsection designations in this section as enacted in 1984 were made pursuant to the statutory revision authority of the Louisiana State Law Institute.

Title of Act:
An Act to enact Chapter 12 of Title 40 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 40:2201 through 2204; relative to contracts between medical care providers and group purchasers; to authorize preferred provider contracts in Louisiana; to provide for definitions; to provide for authorization for hospital service district hospital participation in such contracts; to provide for physician participation in such contracts; and to provide for related matters. Acts 1984, No. 374.

Cross References

Health and accident insurance generally, see R.S. 22:211 et seq.

WESTLAW Electronic Research

See WESTLAW Research Guide following the Preface.

Notes of Decisions

Bidding 1

1. Bidding
Preferred Provider Organization provides professional services which are not subject to the Public Bid Law. Op.Atty.Gen., No. 90-341, July 24, 1990.

§ 2202. Definitions

As used in this Part, the following definitions shall apply:

(1) "Alternative rates of payment" shall mean the rate at which or sum for which the provider agrees to perform specified services. The rate shall be negotiated between purchaser and provider and shall be in effect for a fixed term. It may, but need not, include a discount from the provider's customary fee.

(2)"Governmental body" means any department, commission, council, board, office, bureau, committee, institution, agency, government, corporation, or establishment of the executive branch of this state.

(3) "Group purchaser" shall mean an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization. "Group purchaser" may include:

(a) Entities which contract for the benefit of their insured, employees, or members such as insurers, self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs.

(b) Entities which serve as brokers for the formation of such contracts, including health care financiers, third party administrators, providers or other intermediaries.

(4) "Hospital" shall mean any institution, place, building, or agency, public or private, whether for profit or not, including a facility subject to the jurisdiction of a hospital service district, devoted primarily to the maintenance and operation of facilities for ten or more individuals for the diagnosis, treatment, or care of persons admitted for overnight stay or longer who are suffering from illness, injury, infirmity, deformity, or other physical condition for which obstetrical, medical, or surgical services would be available and appropriate. It may also include nursing homes as defined by and regulated under the provisions of R.S. 40:2009.1 through 2009.12.

(5)(a) "Preferred Provider Organization (P.P.O.)" shall mean a contractual agreement or agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment specified in advance for a defined period of time in which

(i) The provider agrees to accept these alternative rates of payment offered by group purchasers to their members whenever a member chooses to use its services and

(ii) There is a tangible benefit to the provider in offering such alternative rates of payment to the group purchaser.

(b) The contractual agreement or agreements may also include incentives which encourage the insured employee or member to utilize the participating providers.

(c) No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of his license.

(d) However, nothing in this Part shall be construed to require any hospital to grant any provider or class of providers medical staff membership.

(e) Preferred provider contracts should include, but not be limited to, the following components:

(i) Participating in a resource monitoring component to insure quality control both for patient care and cost effectiveness.

(ii) Procedures to encourage prompt payment for services rendered.

(6) "Provider" shall mean one or more entities which offer health care services and shall include but not be limited to hospitals, individuals or groups of physicians, individuals or groups of psychologists, and other health care entities. Any health care entity which is specifically covered by a group purchaser's insurance policy, employee benefits, self funded organization or Taft-Hartley trust benefits or plan shall be construed to be a "provider" for purposes of consideration under this Part.

(7) "Tangible benefit" shall mean but not be limited to:

(a) Any reasonable expectation of a demonstrable increase in or maintenance of usage of the provider's services.

(b) Contractual provisions requiring quality control of patient care and participation in resource monitoring procedures; or

(c) Any reasonable expectation of prompt payment for services rendered. Added by Acts 1984, No. 374, § 1, eff. July 6, 1984.

Historical and Statutory Notes

A prior R.S. 40:2202, part of the former Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § 5. See italic note preceding R S. 40:2201.

The paragraphs in this section as enacted in 1984 were rearranged in alphabetical order pursuant to the statutory revision authority of the Louisiana State Law Institute.

In the last sentence of par. (1), commas surrounding "but need not" were inserted; in par. (3), at the beginning of the first sentence, "purchaser" was changed from "purchasers" and, at the beginning of the second sentence, "Group purchaser" was surrounded by quotation marks; in par. (5), subparagraph and item designations were inserted and items (a) and (b) in subpars. (5)(a) and (5)(e) were redesignated (i) and (ii); and, in the second sentence of present par. (6), quotation marks enclosing "provider" were inserted, all pursuant to the statutory revision authority of the Louisiana State Law Institute.

Library References

Words and Phrases (Perm.Ed.)

§ 2203. Authorization for Preferred Provider Organizations

A. Any group purchaser may contract with any provider in any contractual agreement or agreements to form a preferred provider organization.

B. Such agreement shall not be construed to authorize a group purchaser to furnish medical services unless the purchaser is otherwise licensed to do so, nor shall such agreement authorize a group purchaser to direct or control the provision or selection of forms or types of medical services to the group members.

C. Group purchaser members participating in preferred provider organizations shall be guaranteed access to their standard benefits under the terms of their policy, employee benefits, self funded organization benefits or Taft-Hartley trust benefits, regardless of whether they choose a preferred provider or a provider who does not participate in the preferred provider contract.

D. Any entity serving as a broker or intermediary under the provisions of R.S. 40:2202(3)(b) who contracts to write or sell insurance shall be subject to

the provisions of Title 22 of the Louisiana Revised Statutes of 1950. However, any entity which serves as a broker or intermediary for the formation of a preferred provider organization for a governmental body shall not be entitled to collect any fee for serving as such broker or intermediary under this Part.

E. Any person requiring emergency medical services shall be entitled to use any available provider without being denied the basic benefits provided under his policy or benefits program.

Added by Acts 1984, No. 374, § 1, eff. July 6, 1984.

Historical and Statutory Notes

A prior R.S. 40:2203, part of the former Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § 5. See italic note preceding R.S. 40:2201.

The paragraphs of this section as enacted in 1984 were rearranged in alphabetical order pursuant to the statutory revision authority of the Louisiana State Law Institute.

Notes of Decisions

Group purchaser 1

1. Group purchaser

Board of Trustees of the State Employees Group Benefit Program has authority to negotiate discount programs with medical providers according to the definition of "group purchaser" in R.S. 40:2203 and the power granted in R.S. 42:874. Op.Atty.Gen., No. 87-831, Jan. 20, 1988.

§ 2204. Hospital participation; tangible benefit presumed

A. Whenever any hospital or governmental body is a party to a preferred provider organization contract, there shall be a rebuttable presumption that such hospital or governmental body contracted with the expectation of receiving a tangible benefit rather than making a donation of services in violation of Section 14(A) of Article VII of the Constitution of Louisiana.

B. Unless clearly indicated otherwise in a preferred provider organization contractual arrangement, it shall be presumed that the hospital, governmental body, or other provider negotiated the contract with the knowledge that such agreement would result in a tangible benefit to the hospital or governmental body and would not constitute a donation of its services to a group purchaser in violation of the Constitution of Louisiana, Article VII, Section 14(A).

C. Whenever a hospital or governmental body is a party to a preferred provider organization contract, the provisions of R.S. 39:1481 et seq. shall not apply.

D. The Board of Trustees of the State Employees Group Benefits Program shall develop criteria governing the state's participation in preferred provider organization contracts which shall be subject to the approval of appropriate standing committees of the legislature having jurisdiction over review of agency rules of the State Employees Group Benefits Program as designated by R.S. 49:968(B)(15) or the subcommittees on oversight of such standing committees, the office of contractual review of the division of administration, and the office of the state treasurer, any of which shall have the authority to approve or disapprove such criteria. Any contract awarded under the provisions of this

Section shall be approved by the Board of Trustees of the State Employees Group Benefits Program.

Added by Acts 1984, No. 374, § 1, eff. July 6, 1984. Amended by Acts 1990, No. 585 § 1, eff. July 19, 1990.

Historical and Statutory Notes

A prior R.S. 40:2204, part of the Louisiana Air Control Law, was repealed by Acts 1979, No. 449, § S. See italic note preceding R.S. 40:2201

The 1990 amendment rewrote subsec- D which had read:

"D. The board of Trustees of the State Employee Group Benefits Program shall develop criteria governing the state's participation in preferred provider organization contracts which shall be subject to the approval of the Joint Committee on the Budget. Any contract awarded under the provisions of this Section shall be approved by the Board of Trustees of the State Employee Group Benefits Program."

§ 2205. Utilization reviews; relief from liability and discovery; standards compliance

Notwithstanding any other provision of law, any health care provider licensed in this state who participates in quality of care or utilization reviews by a peer review committee, as a peer review committee member or a treating health care provider whose patients are subject to such review and have been contracted, employed, or hired by a group purchaser shall be immune from liability for any act performed during such reviews of the activities of similarly licensed health care providers if such person acts without malice, makes a reasonable effort to obtain the facts, and believes that the action taken is warranted by the facts. A peer review committee shall not be subject to discovery, and no person in attendance at such reviews shall be required to testify as to what transpired at such reviews. The utilization review requirements and administrative treatment guidelines of the peer review committee employed or hired by the group purchaser shall not fall below the appropriate standard of care and shall not impinge upon the independent medical judgment of the treating health care provider.

Added by Acts 1991, No. 876, § 1.

Historical and Statutory Notes

A prior R.S. 40:2205 was repealed by Acts 1979, No. 449, § 5. See italic note preceding R.S. 40:2201.

§§ 2206 to 2216. Repealed by Acts 1979, No. 449, § 5, eff. Jan. 1,1980

Historical and Statutory Notes

Acts 1979, No. 449, § 5, effective January 1, 1980, repealed former Chapter 12, which consisted of R.S. 40:2201 to 40:2216 as added by Acts 1964, No. 259, § 1 et seq., pertaining to air pollution control. Act 449, in § 1, also enacted the Louisiana Environmental Affairs Act (R.S. 30:1051 et seq., redesignated as R.S. 30:2001 et seq. and renamed the Louisiana Environmental Quality Act), Part III of which (R.S. 30:1081 et seq., redesignated as R.S. 30:205 et seq.), the Louisiana Air Control Law, relates to the subject matter of this repealed Chapter. Prior to the repeal, Acts 1978, No. 615, § 1 had amended R.S. 40:2202 and 40:2204, Acts 1978. No. 786, § 5 had amended R.S. 40:2203 and 40:2204, Acts 1978 No. 383, § 1 had amended R.S. 40:2204, and Acts 1978, No. 383, § 2 had amended R.S. 40:2212.

APPENDIX F

CONSTITUTION OF THE STATE OF LOUISIANA OF 1974

PREAMBLE

We, the people of Louisiana, grateful to Almighty God for the civil, political, economic, and religious liberties we enjoy, and desiring to protect individual rights to life, liberty, and property; afford opportunity for the fullest development of the individual; assure equality of rights; promote the health, safety, education, and welfare of the people; maintain a representative and orderly government; ensure domestic tranquility; provide for the common defense; and secure the blessings of freedom and justice to ourselves and our posterity, do ordain and establish this constitution.